SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Medicare Supplement
TOI: MS08G Group Medicare Supplement - Standard Plans 2010
Sub-TOI: MS08G.001 Plan A 2010
Filing Type: Form/Rate/Advertisement

SERFF Tr Num: AEGX-126253189
SERFF Status: Closed-Approved-Closed
Co Tr Num: HM AR0050607C01

Author: SPI ADMSLH
Date Submitted: 08/03/2009

State: Arkansas
State Tr Num: 43111
State Status: Approved-Closed
Reviewer(s): Stephanie Fowler
Disposition Date: 09/10/2010
Disposition Status: Approved-Closed
Implementation Date:

Implementation Date Requested:
State Filing Description:

General Information

Project Name: Medicare Supplement
Project Number: HM AR0050607C01
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Filing Status Changed: 09/10/2010

Deemer Date:
Submitted By: SPI ADMSLH
Filing Description:
NAIC #468-86231
Forms, Rates and Advertising Filing

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Association, Discretionary, Employer, Trust
Explanation for Other Group Market Type:
State Status Changed: 09/30/2009
Created By: SPI ADMSLH
Corresponding Filing Tracking Number:

RE: MS8000GPT-A.AR et al. - Medicare Supplement Insurance Program
Company Filing#: HM AR0050607C01

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

The above referenced forms are being submitted for your review and approval. These forms are new and in compliance with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) will replace previously approved forms MS4500GPT-A.AR et al which were approved by your department on January 25, 2004 under Department File # 27596. Upon approval, these forms will only be issued with an effective date of June 1, 2010 or later.

Other than the changes required to comply with MIPPA, these forms are the same as those filed and approved for form MS4500GPT-A.AR et al. As with our previously approved filing, the group policy will be issued direct in Arkansas or marketed through an out-of-state trust policy and coverage will be marketed to sponsored association groups and financial institutions on a direct response, mass marketed basis.

Included in this submission are: the 10 Standardized Medicare Supplement Insurance Plans A through D, Plans F and G and Plans K through N (we will not offer high Deductible Plan F), the required outline of coverage, application, rates and actuarial materials, and advertising material that will be used with this product.

These forms are being filed concurrently in our domicile state of Iowa.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Forms including in Filing:
Group Medicare Supplement Insurance Program
Group Policies:
MS8000GPT-A.AR - Group Medicare Supplement Insurance Policy Plan A
MS8000GPT-B.AR - Group Medicare Supplement Insurance Policy Plan B
MS8000GPT-C.AR - Group Medicare Supplement Insurance Policy Plan C
MS8000GPT-D.AR - Group Medicare Supplement Insurance Policy Plan D
MS8000GPT-F.AR - Group Medicare Supplement Insurance Policy Plan F
MS8000GPT-G.AR - Group Medicare Supplement Insurance Policy Plan G
MS8000GPT-K.AR - Group Medicare Supplement Insurance Policy Plan K
MS8000GPT-L.AR - Group Medicare Supplement Insurance Policy Plan L
MS8000GPT-M.AR - Group Medicare Supplement Insurance Policy Plan M
MS8000GPT-N.AR - Group Medicare Supplement Insurance Policy Plan N

Group Certificates of Insurance:
MS8000GCT-A.AR - Group Medicare Supplement Insurance Certificate Plan A
MS8000GCT-B.AR - Group Medicare Supplement Insurance Certificate Plan B

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

MS8000GCT-C.AR - Group Medicare Supplement Insurance Certificate Plan C
MS8000GCT-D.AR - Group Medicare Supplement Insurance Certificate Plan D
MS8000GCT-F.AR - Group Medicare Supplement Insurance Certificate Plan F
MS8000GCT-G.AR - Group Medicare Supplement Insurance Certificate Plan G
MS8000GCT-K.AR - Group Medicare Supplement Insurance Certificate Plan K
MS8000GCT-L.AR - Group Medicare Supplement Insurance Certificate Plan L
MS8000GCT-M.AR - Group Medicare Supplement Insurance Certificate Plan M
MS8000GCT-N.AR - Group Medicare Supplement Insurance Certificate Plan N

MS8000GOTCS - Outline of Coverage, Group Plans, A-D, F, G, K-N

MS8000GAT.AR - Application Form

Advertising Forms:
MSBRO2010 - Brochure
MSBKS2010 - Buck Slip
MSLTR2010CS - Solicitation Letter
MSINFS2010 - Information Sheet
MSQA2010CS - Question and Answer Sheet
MSRS2010 - Rate Sheet Page
MSRSBDY2010 - Birthday Rate Sheet Page
MSRSGI2010 - General Inquiry Rate Sheet Page

Company and Contact

Filing Contact Information

Edward Weigand, Director, Product Filing, Compliance and Licensing	eweigand@aegonusa.com
520 Park Avenue	410-685-5500 [Phone] 5265 [Ext]
Baltimore, MD 21201	410-209-5910 [FAX]

Filing Company Information

Transamerica Life Insurance Company	CoCode: 86231	State of Domicile: Iowa
4333 Edgewood Road, N.E.	Group Code: 468	Company Type: Life and Health
Cedar Rapids, IA 52499	Group Name:	State ID Number:
(410) 685-5500 ext. [Phone]	FEIN Number: 39-0989781	

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$275.00
Retaliatory?	No
Fee Explanation:	ARKANSAS filing fee: $50 per form submission + $50 per rate filing + (7 x $25 per advertisement = $175) = $275
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	$275.00	08/03/2009	29597022
Transamerica Life Insurance Company	$725.00	08/19/2009	29951148

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
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Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	09/10/2010	09/10/2010
Approved-Closed	Stephanie Fowler	09/30/2009	09/30/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	09/16/2009	09/16/2009	SPI ADMSLH	09/21/2009	09/21/2009
Pending Industry Response	Stephanie Fowler	08/19/2009	08/19/2009	SPI ADMSLH	08/19/2009	08/19/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Expand Eligible Groups	Note To Reviewer	SPI ADMSLH	09/07/2010	09/07/2010
Re-Open Filing	Note To Reviewer	SPI ADMSLH	09/07/2010	09/07/2010

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Disposition

Disposition Date: 09/10/2010
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	**Overall % Indicated Change:**	**Overall % Rate Impact:**	**Written Premium Change for this Program:**	**# of Policy Holders Affected for this Program:**	**Written Premium for this Program:**	**Maximum % Change (where required):**	**Minimum % Change (where required):**
Transamerica Life Insurance Company	%	%	$		$	%	%

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	No
Supporting Document	Application	Accepted for Informational Purposes	No
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage	Accepted for Informational Purposes	No
Supporting Document	AR Cover Letter MS8000	Accepted for Informational Purposes	No
Supporting Document	Explanation of Variables MS8000	Accepted for Informational Purposes	No
Supporting Document	Explanation of Variables for MS8000GAT	Accepted for Informational Purposes	No
Supporting Document	Explanation of Variables - MSLTR2010	Accepted for Informational Purposes	No
Form *(revised)*	Application	Approved	No
Form	Application	Disapproved	No
Form *(revised)*	Plan A Certificate	Approved	No
Form	Plan A Certificate	Disapproved	No
Form *(revised)*	Plan B Certificate	Approved	No
Form	Plan B Certificate	Disapproved	No
Form *(revised)*	Plan C Certificate	Approved	No
Form	Plan C Certificate	Disapproved	No
Form *(revised)*	Plan D Certificate	Approved	No
Form	Plan D Certificate	Disapproved	No
Form *(revised)*	Plan F Certificate	Approved	No
Form	Plan F Certificate	Disapproved	No
Form *(revised)*	Plan G Certificate	Approved	No
Form	Plan G Certificate	Disapproved	No
Form *(revised)*	Plan K Certificate	Approved	No
Form	Plan K Certificate	Disapproved	No
Form *(revised)*	Plan L Certificate	Approved	No
Form	Plan L Certificate	Disapproved	No

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Form *(revised)*	Plan M Certificate	Approved	No
Form	Plan M Certificate	Disapproved	No
Form *(revised)*	Plan N Certificate	Approved	No
Form	Plan N Certificate	Disapproved	No
Form	Outline of Coverage	Approved	No
Form *(revised)*	Plan A Master Policy	Approved	No
Form	Plan A Master Policy	Disapproved	No
Form *(revised)*	Plan B Master Policy	Approved	No
Form	Plan B Master Policy	Disapproved	No
Form *(revised)*	Plan C Master Policy	Approved	No
Form	Plan C Master Policy	Disapproved	No
Form *(revised)*	Plan D Master Policy	Approved	No
Form	Plan D Master Policy	Disapproved	No
Form *(revised)*	Plan F Master Policy	Approved	No
Form	Plan F Master Policy	Disapproved	No
Form *(revised)*	Plan G Master Policy	Approved	No
Form	Plan G Master Policy	Disapproved	No
Form *(revised)*	Plan K Master Policy	Approved	No
Form	Plan K Master Policy	Disapproved	No
Form *(revised)*	Plan L Master Policy	Approved	No
Form	Plan L Master Policy	Disapproved	No
Form *(revised)*	Plan M Master Policy	Approved	No
Form	Plan M Master Policy	Disapproved	No
Form *(revised)*	Plan N Master Policy	Approved	No
Form	Plan N Master Policy	Disapproved	No
Form	Brochure	Filed	No
Form	Buckslip	Filed	No
Form	Information Sheet	Filed	No
Form	Solicitation Letter	Filed	No
Form	Question and Answer Sheet	Filed	No
Form	Rate Sheet	Filed	No
Form	Birthday Rate Sheet	Filed	No
Rate	Arkansas Rate Sheet	Approved	No

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Disposition

Disposition Date: 09/30/2009
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	**Overall % Indicated Change:**	**Overall % Rate Impact:**	**Written Premium Change for this Program:**	**# of Policy Holders Affected for this Program:**	**Written Premium for this Program:**	**Maximum % Change (where required):**	**Minimum % Change (where required):**
Transamerica Life Insurance Company	%	%	$		$	%	%

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	No
Supporting Document	Application	Accepted for Informational Purposes	No
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage	Accepted for Informational Purposes	No
Supporting Document	AR Cover Letter MS8000	Accepted for Informational Purposes	No
Supporting Document	Explanation of Variables MS8000	Accepted for Informational Purposes	No
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Supporting Document	Explanation of Variables - MSLTR2010	Accepted for Informational Purposes	No
Form *(revised)*	Application	Approved	No
Form	Application	Disapproved	No
Form *(revised)*	Plan A Certificate	Approved	No
Form	Plan A Certificate	Disapproved	No
Form *(revised)*	Plan B Certificate	Approved	No
Form	Plan B Certificate	Disapproved	No
Form *(revised)*	Plan C Certificate	Approved	No
Form	Plan C Certificate	Disapproved	No
Form *(revised)*	Plan D Certificate	Approved	No
Form	Plan D Certificate	Disapproved	No
Form *(revised)*	Plan F Certificate	Approved	No
Form	Plan F Certificate	Disapproved	No
Form *(revised)*	Plan G Certificate	Approved	No
Form	Plan G Certificate	Disapproved	No
Form *(revised)*	Plan K Certificate	Approved	No
Form	Plan K Certificate	Disapproved	No
Form *(revised)*	Plan L Certificate	Approved	No
Form	Plan L Certificate	Disapproved	No

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Form *(revised)*	Plan M Certificate	Approved	No
Form	Plan M Certificate	Disapproved	No
Form *(revised)*	Plan N Certificate	Approved	No
Form	Plan N Certificate	Disapproved	No
Form	Outline of Coverage	Approved	No
Form *(revised)*	Plan A Master Policy	Approved	No
Form	Plan A Master Policy	Disapproved	No
Form *(revised)*	Plan B Master Policy	Approved	No
Form	Plan B Master Policy	Disapproved	No
Form *(revised)*	Plan C Master Policy	Approved	No
Form	Plan C Master Policy	Disapproved	No
Form *(revised)*	Plan D Master Policy	Approved	No
Form	Plan D Master Policy	Disapproved	No
Form *(revised)*	Plan F Master Policy	Approved	No
Form	Plan F Master Policy	Disapproved	No
Form *(revised)*	Plan G Master Policy	Approved	No
Form	Plan G Master Policy	Disapproved	No
Form *(revised)*	Plan K Master Policy	Approved	No
Form	Plan K Master Policy	Disapproved	No
Form *(revised)*	Plan L Master Policy	Approved	No
Form	Plan L Master Policy	Disapproved	No
Form *(revised)*	Plan M Master Policy	Approved	No
Form	Plan M Master Policy	Disapproved	No
Form *(revised)*	Plan N Master Policy	Approved	No
Form	Plan N Master Policy	Disapproved	No
Form	Brochure	Filed	No
Form	Buckslip	Filed	No
Form	Information Sheet	Filed	No
Form	Solicitation Letter	Filed	No
Form	Question and Answer Sheet	Filed	No
Form	Rate Sheet	Filed	No
Form	Birthday Rate Sheet	Filed	No
Rate	Arkansas Rate Sheet	Approved	No

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/16/2009
Submitted Date	09/16/2009
Respond By Date	10/16/2009

Dear Edward Weigand,

This will acknowledge receipt of the captioned filing.

Objection 1

- Plan A Certificate, MS8000GCT-A.AR (Form)
- Plan B Certificate, MS8000GCT-B.AR (Form)
- Plan C Certificate, MS8000GCT-C.AR (Form)
- Plan D Certificate, MS8000GCT-D.AR (Form)
- Plan F Certificate, MS8000GCT-F.AR (Form)
- Plan G Certificate, MS8000GCT-G.AR (Form)
- Plan K Certificate, MS8000GCT-K.AR (Form)
- Plan L Certificate, MS8000GCT-L.AR (Form)
- Plan M Certificate, MS8000GCT-M.AR (Form)
- Plan N Certificate, MS8000GCT-N.AR (Form)
- Plan A Master Policy, MS8000GPT-A.AR (Form)
- Plan B Master Policy, MS8000GPT-B.AR (Form)
- Plan C Master Policy, MS8000GPT-C.AR (Form)
- Plan D Master Policy, MS8000GPT-D.AR (Form)
- Plan F Master Policy, MS8000GPT-F.AR (Form)
- Plan G Master Policy, MS8000GPT-G.AR (Form)
- Plan K Master Policy, MS8000GPT-K.AR (Form)
- Plan L Master Policy, MS8000GPT-L.AR (Form)
- Plan M Master Policy, MS8000GPT-M.AR (Form)
- Plan N Master Policy, MS8000GPT-N.AR (Form)

Comment: Cover Page - Right to Renew - Please remove the last sentence from this paragraph. This statement does not accurately reflect when the company can increase the rates and can be misleading to the insured.

Objection 2

- Application, MS8000GAT.AR (Form)

Comment: Rule 27 s 18 B states "Agents shall list any other health insurance policy they have sold to the applicant. (1) List policies sold which are still in force. (2) List policies sold in the past five (5) years that are no longer in force." Please

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

revise this application.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/21/2009
Submitted Date	09/21/2009

Dear Stephanie Fowler,

Comments:
Thank you for your Objection Letter dated September 16. In response we offer the following:

Response 1

Comments: OBJECTION 1
Schedule Items:
MS8000GCT-A.AR - Plan A Certificate
MS8000GCT-B.AR - Plan B Certificate
MS8000GCT-C.AR - Plan C Certificate
MS8000GCT-D.AR - Plan D Certificate
MS8000GCT-F.AR - Plan F Certificate
MS8000GCT-G.AR - Plan G Certificate
MS8000GCT-K.AR - Plan K Certificate
MS8000GCT-L.AR - Plan L Certificate
MS8000GCT-M.AR - Plan M Certificate
MS8000GCT-N.AR - Plan N Certificate
MS8000GPT-A.AR - Plan A Master Policy
MS8000GPT-B.AR - Plan B Master Policy
MS8000GPT-C.AR - Plan C Master Policy
MS8000GPT-D.AR - Plan D Master Policy
MS8000GPT-F.AR - Plan F Master Policy
MS8000GPT-G.AR - Plan G Master Policy
MS8000GPT-K.AR - Plan K Master Policy
MS8000GPT-L.AR - Plan L Master Policy
MS8000GPT-M.AR - Plan M Master Policy
MS8000GPT-N.AR - Plan N Master Policy

Response to Comment: We have revised the Right to Renew section of the Policies and Certificates by eliminating the last sentence in that provision.

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
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Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

OBJECTION 2
Schedule Items:
MS8000GAT.AR -Application

Response to Comment: To comply with Rule 27 section 18B, we have revised the Replacement Question on the application form to include: list policies sold to you by the company which are still in force; list policies sold to you by the company in the past 5 years that are no longer in force.

Related Objection 1

Applies To:

- Plan A Certificate, MS8000GCT-A.AR (Form)
- Plan B Certificate, MS8000GCT-B.AR (Form)
- Plan C Certificate, MS8000GCT-C.AR (Form)
- Plan D Certificate, MS8000GCT-D.AR (Form)
- Plan F Certificate, MS8000GCT-F.AR (Form)
- Plan G Certificate, MS8000GCT-G.AR (Form)
- Plan K Certificate, MS8000GCT-K.AR (Form)
- Plan L Certificate, MS8000GCT-L.AR (Form)
- Plan M Certificate, MS8000GCT-M.AR (Form)
- Plan N Certificate, MS8000GCT-N.AR (Form)
- Plan A Master Policy, MS8000GPT-A.AR (Form)
- Plan B Master Policy, MS8000GPT-B.AR (Form)
- Plan C Master Policy, MS8000GPT-C.AR (Form)
- Plan D Master Policy, MS8000GPT-D.AR (Form)
- Plan F Master Policy, MS8000GPT-F.AR (Form)
- Plan G Master Policy, MS8000GPT-G.AR (Form)
- Plan K Master Policy, MS8000GPT-K.AR (Form)
- Plan L Master Policy, MS8000GPT-L.AR (Form)
- Plan M Master Policy, MS8000GPT-M.AR (Form)
- Plan N Master Policy, MS8000GPT-N.AR (Form)

Comment:

Cover Page - Right to Renew - Please remove the last sentence from this paragraph. This statement does not accurately reflect when the company can increase the rates and can be misleading to the insured.

Related Objection 2

Applies To:

- Application, MS8000GAT.AR (Form)

Comment:
Rule 27 s 18 B states "Agents shall list any other health insurance policy they have sold to the applicant. (1) List policies sold which are still in force. (2) List policies sold in the past five (5) years that are no longer in force." Please revise this application.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Application	MS8000GAT.AR		Application/Enrollment Form	Initial		0.000	MS8000GAT_AR.PDF
Previous Version							
Application	*MS8000GAT.AR*		*Application/Enrollment Form*	*Initial*		*0.000*	MS8000GAT_AR.PDF
Plan A Certificate	MS8000GCT-A.AR		Certificate	Initial		0.000	MS8000GCT-A_AR.PDF
Previous Version							
Plan A Certificate	*MS8000GCT-A.AR*		*Certificate*	*Initial*		*0.000*	MS8000GCT-A_AR.PDF
Plan B Certificate	MS8000GCT-B.AR		Certificate	Initial		0.000	MS8000GCT-B_AR.PDF

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Previous Version

Plan B Certificate	*MS8000G CT-B.AR*	*Certificate*	*Initial*	*0.000*	MS8000G CT-B_AR.PDF
Plan C Certificate	MS8000G CT-C.AR	Certificate	Initial	0.000	MS8000G CT-C_AR.PDF

Previous Version

Plan C Certificate	*MS8000G CT-C.AR*	*Certificate*	*Initial*	*0.000*	MS8000G CT-C_AR.PDF
Plan D Certificate	MS8000G CT-D.AR	Certificate	Initial	0.000	MS8000G CT-D_AR.PDF

Previous Version

Plan D Certificate	*MS8000G CT-D.AR*	*Certificate*	*Initial*	*0.000*	MS8000G CT-D_AR.PDF
Plan F Certificate	MS8000G CT-F.AR	Certificate	Initial	0.000	MS8000G CT-F_AR.PDF

Previous Version

Plan F Certificate	*MS8000G CT-F.AR*	*Certificate*	*Initial*	*0.000*	MS8000G CT-F_AR.PDF
Plan G Certificate	MS8000G CT-G.AR	Certificate	Initial	0.000	MS8000G CT-G_AR.PD

					F
Previous Version					
Plan G Certificate	*MS8000G CT-G.AR*	*Certificate*	*Initial*	*0.000*	MS8000G CT-G_AR.PDF
Plan K Certificate	MS8000G CT-K.AR	Certificate	Initial	0.000	MS8000G CT-K_AR.PDF
Previous Version					
Plan K Certificate	*MS8000G CT-K.AR*	*Certificate*	*Initial*	*0.000*	MS8000G CT-K_AR.PDF
Plan L Certificate	MS8000G CT-L.AR	Certificate	Initial	0.000	MS8000G CT-L_AR.PDF
Previous Version					
Plan L Certificate	*MS8000G CT-L.AR*	*Certificate*	*Initial*	*0.000*	MS8000G CT-L_AR.PDF
Plan M Certificate	MS8000G CT-M.AR	Certificate	Initial	0.000	MS8000G CT-M_AR.PDF
Previous Version					
Plan M Certificate	*MS8000G CT-M.AR*	*Certificate*	*Initial*	*0.000*	MS8000G CT-M_AR.PDF
Plan N Certificate	MS8000G CT-N.AR	Certificate	Initial	0.000	MS8000G CT-N_AR.PDF

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*		
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*		
Company Tracking Number:	*HM AR0050607C01*				
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*		
Product Name:	*Medicare Supplement*				
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*				

Previous Version

Plan N Certificate	*MS8000G CT-N.AR*	*Certificate*	*Initial*	*0.000*	MS8000G CT-N_AR.PDF
Plan A Master Policy	MS8000G PT-A.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-A_AR.PDF

Previous Version

Plan A Master Policy	*MS8000G PT-A.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-A_AR.PDF
Plan B Master Policy	MS8000G PT-B.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-B_AR.PDF

Previous Version

Plan B Master Policy	*MS8000G PT-B.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-B_AR.PDF
Plan C Master Policy	MS8000G PT-C.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-C_AR.PDF

Previous Version

Plan C Master Policy	*MS8000G PT-C.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-C_AR.PDF
Plan D Master Policy	MS8000G PT-D.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-D_AR.PD

					F
Previous Version					
Plan D Master Policy	*MS8000G PT-D.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-D_AR.PDF
Plan F Master Policy	MS8000G PT-F.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-F_AR.PDF
Previous Version					
Plan F Master Policy	*MS8000G PT-F.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-F_AR.PDF
Plan G Master Policy	MS8000G PT-G.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-G_AR.PDF
Previous Version					
Plan G Master Policy	*MS8000G PT-G.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-G_AR.PDF
Plan K Master Policy	MS8000G PT-K.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-K_AR.PDF
Previous Version					
Plan K Master Policy	*MS8000G PT-K.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-K_AR.PDF
Plan L Master Policy	MS8000G PT-L.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

					L_AR.PDF
Previous Version					
Plan L Master Policy	*MS8000G PT-L.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-L_AR.PDF
Plan M Master Policy	MS8000G PT-M.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-M_AR.PDF
Previous Version					
Plan M Master Policy	*MS8000G PT-M.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-M_AR.PDF
Plan N Master Policy	MS8000G PT-N.AR	Policy/Contract/Fraternal Certificate	Initial	0.000	MS8000G PT-N_AR.PDF
Previous Version					
Plan N Master Policy	*MS8000G PT-N.AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*0.000*	MS8000G PT-N_AR.PDF

No Rate/Rule Schedule items changed.

We hope this satisfies your concerns and review of this submission can continue. If you need any additional information please let me know.

Edward Weigand
410-209-5265
eweigand@aegonusa.com

Sincerely,
SPI ADMSLH

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/19/2009
Submitted Date	08/19/2009
Respond By Date	09/21/2009

Dear Edward Weigand,

This will acknowledge receipt of the captioned filing.

Per Bulletin 7-2005 The correct filing fees are $50.00 for each policy including all forms associated with the policy and filed with the policy and the fee for rates is $50.00 for each form submitted. Please submit the correct filing fee for this filing.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/19/2009
Submitted Date	08/19/2009

Dear Stephanie Fowler,

Comments:
Thank you for your noted of August 19th and for taking the time to talk to me about the required filing fee.

Response 1

Comments: The total Filing Fee required for this submission is $1,000. To arrive at that fee: 10 policy forms at $50 each ($500) plus 10 rate filings for 10 policy forms at $50 each ($500) for a total of $1,000.

Initially a filing fee of $275 was remitted. I have just submitted an additional EFT transaction in the amount of $725. Therefore a total of $1,000 will be remitted for this filing package.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We hope the above explanation meets with your satisfaction and review of this submission can continue.

Edward Weigand
410-209-5265
eweigand@aegonusa.com

Sincerely,
SPI ADMSLH

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Note To Reviewer

Created By:

SPI ADMSLH on 09/07/2010 01:36 PM

Last Edited By:

Stephanie Fowler

Submitted On:

09/08/2010 01:25 PM

Subject:

Expand Eligible Groups

Comments:

At this time we would like to expand issuance to discretionary groups. These groups might include:

Affinity groups including Financial Institutions (such as Credit Unions, Banks and Broker-Dealers),
Retailers and
Credit Card Issuers.

We certify that there will be no changes to the forms due to this expansion.

Thank you,

Cindy Hammonds

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
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TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Note To Reviewer

Created By:

SPI ADMSLH on 09/07/2010 12:31 PM

Last Edited By:

Stephanie Fowler

Submitted On:

09/08/2010 01:25 PM

Subject:

Re-Open Filing

Comments:

We would like to expand the eligible groups for this filing. Could you please open this filing so that I am might submit the additional information?

Thank you,

Cindy Hammonds

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 09/30/2009	MS8000GAT.AR	Application/ Enrollment Form	Application	Initial		0.000	MS8000GAT_AR.PDF
Approved 09/30/2009	MS8000GCT-A.AR	Certificate	Plan A Certificate	Initial		0.000	MS8000GCT-A_AR.PDF
Approved 09/30/2009	MS8000GCT-B.AR	Certificate	Plan B Certificate	Initial		0.000	MS8000GCT-B_AR.PDF
Approved 09/30/2009	MS8000GCT-C.AR	Certificate	Plan C Certificate	Initial		0.000	MS8000GCT-C_AR.PDF
Approved 09/30/2009	MS8000GCT-D.AR	Certificate	Plan D Certificate	Initial		0.000	MS8000GCT-D_AR.PDF
Approved 09/30/2009	MS8000GCT-F.AR	Certificate	Plan F Certificate	Initial		0.000	MS8000GCT-F_AR.PDF
Approved 09/30/2009	MS8000GCT-G.AR	Certificate	Plan G Certificate	Initial		0.000	MS8000GCT-G_AR.PDF
Approved 09/30/2009	MS8000GCT-K.AR	Certificate	Plan K Certificate	Initial		0.000	MS8000GCT-K_AR.PDF
Approved 09/30/2009	MS8000GCT-L.AR	Certificate	Plan L Certificate	Initial		0.000	MS8000GCT-L_AR.PDF
Approved 09/30/2009	MS8000GCT-M.AR	Certificate	Plan M Certificate	Initial		0.000	MS8000GCT-M_AR.PDF
Approved 09/30/2009	MS8000GCT-N.AR	Certificate	Plan N Certificate	Initial		0.000	MS8000GCT-N_AR.PDF
Approved 09/30/2009	MS8000GOTCS	Other	Outline of Coverage	Initial		0.000	MS8000GOTCS.PDF
Approved 09/30/2009	MS8000GPT-A.AR	Policy/Contract/Fraternal Certificate	Plan A Master Policy	Initial		0.000	MS8000GPT-A_AR.PDF
Approved	MS8000GP	Policy/Cont	Plan B Master Policy	Initial		0.000	MS8000GPT-

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*	
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*	
Company Tracking Number:	*HM AR0050607C01*			
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*	
Product Name:	*Medicare Supplement*			
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*			

09/30/2009	T-B.AR	ract/Fratern al Certificate					B_AR.PDF
Approved 09/30/2009	MS8000GPT-C.AR	Policy/Cont ract/Fratern al Certificate	Plan C Master Policy	Initial		0.000	MS8000GPT-C_AR.PDF
Approved 09/30/2009	MS8000GPT-D.AR	Policy/Cont ract/Fratern al Certificate	Plan D Master Policy	Initial		0.000	MS8000GPT-D_AR.PDF
Approved 09/30/2009	MS8000GPT-F.AR	Policy/Cont ract/Fratern al Certificate	Plan F Master Policy	Initial		0.000	MS8000GPT-F_AR.PDF
Approved 09/30/2009	MS8000GPT-G.AR	Policy/Cont ract/Fratern al Certificate	Plan G Master Policy	Initial		0.000	MS8000GPT-G_AR.PDF
Approved 09/30/2009	MS8000GPT-K.AR	Policy/Cont ract/Fratern al Certificate	Plan K Master Policy	Initial		0.000	MS8000GPT-K_AR.PDF
Approved 09/30/2009	MS8000GPT-L.AR	Policy/Cont ract/Fratern al Certificate	Plan L Master Policy	Initial		0.000	MS8000GPT-L_AR.PDF
Approved 09/30/2009	MS8000GPT-M.AR	Policy/Cont ract/Fratern al Certificate	Plan M Master Policy	Initial		0.000	MS8000GPT-M_AR.PDF
Approved 09/30/2009	MS8000GPT-N.AR	Policy/Cont ract/Fratern al Certificate	Plan N Master Policy	Initial		0.000	MS8000GPT-N_AR.PDF
Filed 09/30/2009	MSBR02010	Advertising	Brochure	Initial			MSBR02010.PDF

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Filed 09/30/2009	MSBKS2010	Advertising	Buckslip	Initial			MSBKS2010.PDF
Filed 09/30/2009	MSINFS2010	Advertising	Information Sheet	Initial			MSINFS2010.PDF
Filed 09/30/2009	MSLTR2010CS	Advertising	Solicitation Letter	Initial			MSLTR2010CS.PDF
Filed 09/30/2009	MSQA2010CS	Advertising	Question and Answer Sheet	Initial			MSQA2010CS.PDF
Filed 09/30/2009	MSRS2010	Advertising	Rate Sheet	Initial			MSRS2010.PDF
Filed 09/30/2009	MSRSBDY2010	Advertising	Birthday Rate Sheet	Initial			MSRSBDY2010.PDF

A

ABC Association

TRANSAMERICA LIFE INSURANCE COMPANY

[Enrollment][Application] Form

Prepared For: [Sample A. Sample]

[Street address
Address 2
City, state, zip code]

B

o [Check here to…] [see Explanation of Variability]
[_____ M _____]

E [PLEASE REPLY BY: [MONTH DAY, YEAR]

Medicare Supplement Insurance Protection Application Form
Underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA 52499

TO APPLY:

1. Complete sections 1-3.

2. Sign section 4.

3. Return in [postage-paid][enclosed] envelope. [Send no money.][Include a check for your initial premium payment.] [Please enclose your check for your first premium payment for the Plan you've chosen. Make it payable to [Transamerica Life Insurance Company][ABC Administrator].] C

[This application…] D

Applicant: [Sample A. Sample]

[Date of Birth: [Month XX, XXXX]

State: [ST]

F

[1. APPLICANT INFORMATION] [1A. APPLICANT INFORMATION]

Telephone #: (_____) _____

Social Security #: _____-_____-_____

Sex: o Male o Female [Height ____ Weight _____]

Desired [effective] date of coverage: _____

You may use this application form if you are turning age 65 and first enrolling in Medicare Part B. H

Please fill in the following information found on your Medicare ID Card

MEDICARE HEALTH INSURANCE

Medicare Claim Number_____

Hospital (Part A) Effective Date_____/____(mo/yr)

Medical (Part B) Effective Date_____/____(mo/yr)

Are both Medicare Parts A & B coverage active?

o Yes o No

[1b. SPOUSE INFORMATION (IF APPLYING)] G

Name: _____

Date of Birth: _____/_____/_____ (Month/Day/Year)

Social Security #: _____-____-_____

Sex: o Male o Female [Height ____ Weight _____]

Medicare ID #: _____(Found on your Medicare ID Card)

Desired [effective] date of coverage: __ _____/_____/_____

(Month/Day/Year)

Effective date of Medicare Part B Coverage:_____

(Found on your Medicare ID Card)

2. PLAN SELECTION [(please answer the question and indicate your plan choice)] G

G

Have you used tobacco products in the past 12 months?

Applicant: o Yes o No Plan Choice: _____ **Spouse:** o Yes o No Plan Choice: _____

Please refer to the rate sheet for your premium amount.

Please note: If you are eligible for guaranteed acceptance (see 3a) your coverage will be issued at the non-tobacco rate.

H

I wish to apply for…

Plan A o $XXX.XX **Plan B o $XXX.XX** **Plan C o $XXX.XX** **Plan F o $XXX.XX** **Other_____**

Billing Method: (please select one):

[o Direct Billing [(get a 5% discount with annual direct billing)]

[o Credit Card] [(get a 5% discount)] [o Automatic Bank Draft][Electronic Fund Transfer] [(get a 5% discount)]

I

[Please complete the EasyPay form if you choose Credit Card or Automatic Bank Draft.] [Please complete the APO form if you choose Electronic Fund Transfer.]

Billing Frequency: (please select one)

[o Annual
(once a year)]

[o Semi-Annual
(two times a year)]

[o Quarterly
(four times per year)]

[o Monthly
(twelve times per year)]

G

3. [PLEASE ANSWER THESE QUESTIONS]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. To the best of my knowledge-

H

3. [PLEASE ANSWER THE FOLLOWING QUESTION]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. To the best of my knowledge-

Are you applying during an Open Enrollment Period?* • If you answered YES to the question above, your ACCEPTANCE IS GUARANTEED. • If you answered NO to the question above, please call [1-800-749-6983] for a new application. Medicare Supplement applicants applying for coverage outside of the Open Enrollment or Guaranteed Issue Periods are subject to underwriting. *Open Enrollment means that you will not be denied coverage based on your health if your Transamerica Life Insurance Company Medicare Supplement application is submitted during the six-month period beginning with the first month in which you, at age 65 or older, enroll in Medicare Part B.	Applicant o Yes o No **H**

	Applicant	Spouse
3a. Your Acceptance May Be Guaranteed **G**		
• Did you turn age 65 in the last 6 months?	o Yes o No	o Yes o No
• Did you enroll in Medicare Part B in the last 6 months?	o Yes o No	o Yes o No
• If yes, what is the effective date?_____	_____	_____
If you answered yes to both questions skip to section 4		
3b. Premium Assistance Questions (Questions we are required to ask)		
Are you covered for medical assistance through the state Medicaid program: (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)	o Yes o No	o Yes o No
• Will Medicaid pay your premiums for this Medicare supplement policy?	o Yes o No	o Yes o No
• Do you receive any benefits from Medicard OTHER THAN payments toward your Medicare Part B premium?	o Yes o No	o Yes o No
3c. Replacement Questions – answer <u>only</u> if you are replacing coverage		
What are your dates of coverage under the other policy?	Start_____	Start_____
	End _____	End _____
• **Medicare Advantage**		
a. If you had coverage from any Medicare plan <u>other than</u> the original Medicare within the past 63 days (for example, a Medicare Advantage plan, or Medicare HMO, or PPO) fill in your start and end dates below. If you are still covered under this plan leave "END" blank.	Start_____	Start_____
	End _____	End _____
b. If you are still covered under the Medicare plan,do you intend to replace your current coverage with this new Medicare policy?	o Yes o No	o Yes o No
• **Medicare Supplement**		
a. Was this your first time in this type of Medicare plan?	o Yes o No	o Yes o No
b. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	o Yes o No	o Yes o No
c. Do you have another Medicare supplement policy in force?	o Yes o No	o Yes o No
d. If so, with what company, and what plan do you have? _____		
e. If so, do you intend to replace your current Medicare supplement policy with this policy?	o Yes o No	o Yes o No
• **Other**		
a. Have you had coverage under any other health insurance within the past 63days? (for example, an employer, union, or individual plan)	o Yes o No	o Yes o No
b) If so, with what company and what kind of policy?		
f. List policies sold to you by the company which are still in force. _____ _____		
g. List policies sold to you by the company in the last 5 years that are no longer in force. _____		

3 d) Health Question	Applicant	Spouse
Within the past 2 years, have you ever: had treatment, been recommended, been hospitalized for, or been advised by any member of the medical profession for Alzheimer's Disease, a liver disease, a kidney disease or disorder?	o Yes o No	o Yes o No
§ **Any person responding yes to this question is not eligible for this plan.**		

4. IMPORTANT. PLEASE READ AND SIGN.

I hereby apply for Medicare Supplement coverage issued by Transamerica Life Insurance Company. I understand that this coverage will not pay benefits for conditions for which I have received medical treatment or advice within the last 6 months prior to the effective date until I have been insured for 6 consecutive months. If this plan replaces creditable coverage, such as Medicare Supplement Insurance or primary hospital and medical reimbursement coverage, that has been in force within the past 63 days, or if I am an Eligible Person* enrolled within 63 days of termination, then this pre-existing conditions limitation will be waived to the extent it was satisfied under the replaced coverage.

J

[AR, DC, LA, ME, NM, OH, and OK Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines or confinement in prison.]

[Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information, concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[Tennessee Residents; It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.]

PLEASE SIGN HERE

Applicant's Signature X _____ Date _____

G [Spouse's Signature (if applying) X_____ Date_____]

PLEASE MAIL YOUR COMPLETED, SIGNED [ENROLLMENT][APPLICATION][FORM] IN THE POSTAGE-PAID ENVELOPE, TO:

[Medicare Supplement Department][ABC Administrator][street address] [city][state][zip] K

[QUESTIONS? PLEASE CALL US AT [1-800-749-6983]
WEEKDAYS FROM [8:30 A.M. TO 6:00 P.M., EASTERN TIME]. We're Here to Help.] L

To apply by phone call [1-800-xxx-xxxx from [8:00 a.m. to 6:00 p.m.], Eastern Time, Monday through Friday]. [To apply on-line visit our website [www.abcdefghijk]. L

Underwritten by Transamerica Life Insurance Company under Group Policy No MS8000GPT

MEDICARE SUPPLEMENT INFORMATION TO CONSIDER
• You do not need more than one Medicare Supplement policy or certificate. • If you purchase this certificate, you may want to evaluate your existing health coverage and decide if you need multiple coverages. • You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy or certificate. • If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement certificate can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent policy or certificate) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. • If you are eligible for, and have enrolled in a Medicare supplement certificate or policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement certificate or policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement certificate or policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent certificate or policy) will be resinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement certificate or policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. • Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan A

Hospital Benefits **Part A**	• This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150. • Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.
Blood Benefit **Part A & B**	• This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.
Medical Benefits **Part B**	• This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of

any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;

(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN A

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you

are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time

written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan B

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;

(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN B

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan C

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;

(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN C

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan D

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;

(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN D

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A

Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group

health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Schedule Page (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Schedule Page. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan F

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**]**.

SICKNESS means an illness or disease, which **[**first**]** manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN F

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

MEDICARE PART B EXCESS BENEFIT

You will receive an additional benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if your Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**]** , before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**]** . Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**]** .

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of the application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
   (a) provide continuation of benefits contained in the Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:

(a) the conversion coverage provided under item (1) above; or
(b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to all Covered Persons covered under the Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**]** . **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan G

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN G

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B EXCESS BENEFIT

You will receive an additional benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if your Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan K

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 50% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit
Part A & B

- This Plan pays 50% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits
Part B

- This Plan pays 50% of the cost sharing of Medicare Eligible Expenses, for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 50% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 50% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**4,140**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN K

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 50% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay 50% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for you, until the Out of Pocket Limit has been met, then 100%.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 50% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After you have reached the Out of Pocket Limit shown on the Certificate Schedule, you will receive benefits when we receive proof that, while insured, you incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Certificate Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan L

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 75% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit
Part A & B

- This Plan pays 75% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits
Part B

- This Plan pays 75% of the cost sharing of Medicare Eligible Expenses, for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 75% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 75% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**2,070**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN L

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 75% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay 75% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for you, until the Out of Pocket Limit has been met, then 100%.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 75% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 75% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After you have reached the Out of Pocket Limit shown on the Certificate Schedule, you will receive benefits when we receive proof that, while insured, you incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Certificate Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan M

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;

(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN M

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A

Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group

health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for two years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	**[**JOSEPHINE SAMPLE**]**
[Policy:	**[**MZ0000000H0000A**]]**
[Certificate Number:	**[**SAMPPROD**]]**
[Policyholder:	**[**ABC ASSOCIATION**]]**
[Effective Date of Coverage:	**[**January 01, 2010**]]**
[[Semi-Annual**]** Premium:	**[**$50.00**]]**
[Covered Person's Age At Issue:	**[**65**]]**

Supplemental Medicare Expense Benefits
Plan N

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, other than the co-payment amounts shown below, subject to the Medicare Part B Deductible.

• **Office Visit Co-Payment**	• $**[**20**]** per office visit
• **Emergency Room Co-Payment**	• $**[**50**]** per emergency room visit (waived if you are admitted to the Hospital and the emergency

visit is subsequently covered as a Medicare Part A Eligible Expense)

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.
Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN N

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you, except as provided in items (3) and (4) that follows.

(3) You must pay the lesser of $**[**20**]** or the Medicare Part B coinsurance or co-payment, shown in the Certificate Schedule, for each covered health care provider office visit, including visits to medical specialist.

(4) You must pay the lesser of $**[**50**]** or the Medicare Part B coinsurance or co-payment, shown in the Certificate Schedule, for each visit to an emergency room of a Hospital. This emergency room co-payment will be waived if you are admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense.

If you discontinue or lapse Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 100% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

Transamerica Life Insurance Company
Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart show the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I and J are no longer available for sale.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance

Plan A	Plan B	Plan C	Plan D	Plan F or F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance *	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $[4.620]; paid at 100% after limit reached	Out-of-pocket limit $[2,310]; paid at 100% after limit reached		
Monthly Age Rate									
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]
Monthly Age Rate with [5%] Smart Rewards Payment Discount									
[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	]$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]	[$XXX.XX]

*Plans F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,000]. Out-of pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. Please note: High Deductible Plan F is currently not available as part of this program.

Transamerica Life Insurance Company

Medicare Supplement Plans

About Your Certificate

Premium Information

We, Transamerica Life Insurance Company, can only raise your premium if we raise the premium for all certificates like yours in this state.

Disclosures

Use this outline to compare benefits and premiums among policies

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans, H, I and J are no longer available for sale.

Read Your Certificate Very Carefully

This is only an outline describing your Certificate's most important features. The Group Policy is the insurance contract. You must read the Certificate itself to understand all of the rights and duties of both you and Transamerica Life Insurance Company.

Right To Return Certificate

If you find that you are not satisfied with your Certificate, you may return it to Transamerica Life Insurance Company, 520 Park Avenue, Baltimore, Maryland 21201-4500.

If you send the Certificate back to us within 30 days after you receive it, we will treat the Certificate as if it had never been issued and return all of your payments.

Certificate Replacement

If you are replacing another health insurance Certificate, do NOT cancel it until you have actually received your new Certificate and are sure you want to keep it.

Notice

- The Certificate may not fully cover all of your medical costs.
- Transamerica Life Insurance Company is not connected with Medicare.
- This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

Complete Answers Are Very Important

When you fill out the application for the new Certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your Certificate and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Plan A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	$0	[$1,068] (Part A deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible]
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Plan B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible]
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

Plan C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Plan C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, sch as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Plan D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPTIAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services: Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
]

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0***
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Plan F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPTIAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services: Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First [$135] of Medicare-Approved Amounts*	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Plan G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts*	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA:			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$4,620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (•) in the chart below. Once your reach the annual limit, the plans pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$534](50% of Part A deductible)	[$534](50% of Part A deductible)•
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0***
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$66.75] a day	Up to [$66.75] a day•
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%•
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of copayment/ coinsurance•

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Plan K

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

****Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENTI, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First [$135] of Medicare-Approved Amounts****	$0	$0	[$135] (Part B deductible)****•
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10%•
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs(and they do not count toward annual out-of-pocket limit of [$4,620])*
BLOOD			
First 3 pints	$0	50%	50%•
First [$135] of Medicare-Approved Amounts****	$0	$0	[$135] (Part B Deductible]****•
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% •
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approve amount to [$4620] per year. However, this limits does NOT include charge form your provider that exceed Medicare-approved amounts (these are called " Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service**.**

PLAN K

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services And medical supplies Durable medical equipment:	100%	$0	$0
First [$135] of Medicare-Approved Amounts*****	$0	$0	[$135] (Part B Deductible) •
Remainder of Medicare-Approved Amounts	80%	10%	10% •

***** Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Plan L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of [$2,310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (•) in the chart below. Once your reach the annual limit, the plans pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$801](75% of Part A deductible)	[$267](25% of Part A deductible) •
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0***
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare – approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$100.13] a day	Up to [$33.38] a day•
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% •
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance•

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Plan L

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

****Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES –IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
First [$135] of Medicare-Approved Amounts****	$0	$0	[$135] (Part B deductible)**** •
Preventive Benefits for Medicare covered services	Generally 75% or mor e of Medicare approved amounts	Remainder of Medicare approved amounts	$All cost above Medicare approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All costs (and they do not count toward out-of-pocket limit of [$2,310])*
BLOOD			
First 3 pints	$0	75%	25% •
First [$135] of Medicare-Approved Amounts****	$0	$0	[$135] (Part B Deductible] •
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	Generally 5% •
CLINICAL LABORATORY SERVICES			
TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approve amount to [$2,310] per year. However, this limits does NOT include charge form your provider that exceed Medicare-approved amounts (these are called " Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan L

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment:			
First [$135] of Medicare-Approved Amounts******	$0	$0	[$135] (Part B Deductible) •
Remainder of Medicare-Approved Amounts	80%	15%	5% •

***** Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Plan M

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1,068]	[$534](50% of Part A deductible)	[$534](50% of Part A deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	
91st day and after:			
While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
Once lifetime reserve days are used:			
Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	$0**
			All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare -approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to[$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Plan M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First [$135] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	$0 Generally 80%	$0 Generally 20%	[$135] (Part B deductible) $0
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD First 3 pints First [$135] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	$0 $0 80%	All costs $0 20%	$0 [$135] (Part B Deductible] $0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services: Medically necessary skilled care services and medical supplies Durable medical equipment: First [$135] of Medicare-Approved Amounts** Remainder of Medicare-Approved Amounts	100% $0 80%	$0 $0 20%	$0 [$135] (Part B Deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

** Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

Plan N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies: First 60 days	All but [$1,068]	[$1,068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:	All but [$534] a day	[$534] a day	$0
While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days (lifetime)	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare -approved facility within 30 days after leaving the hospital: First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any differences between its billed charges and the amount Medicare would have paid.

Plan N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

*Once you have been billed [$135] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: First [$135] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	$0 Generally 80%	$0 Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	[$135] (Part B deductible) Up to {$20] per office visit and up to [$50] per emergency room visit. The copayment of [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare- Approved Amounts)	$0	$0	All Costs
BLOOD First 3 pints First [$135] of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	$0 $0 80%	All costs $0 20%	$0 [$135] (Part B Deductible] $0
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE- APPROVED SERVICESL Medically necessary skilled care services And medical supplies Durable medical equipment: First [$135] of Medicare-Approved Amounts** Remainder of Medicare-Approved Amounts	100% $0 80%	$0 $0 20%	$0 [$135] (Part B Deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA: First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

**Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan A

Core Benefits

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person’s application and the first premium. The Effective Date of Coverage will be shown on the Covered Person’s certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person’s insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN A

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group

health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime.

No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time

written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan B

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Persons' application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN B

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90

days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan C

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of

The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN C

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90

days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after three years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan D

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN D

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care

while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person

provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan F

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B

- This Plan pays 100% of the Medicare Part B

Deductible Benefit	Deductible per Calendar Year.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which **[**first**]** manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN F

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of

Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

MEDICARE PART B EXCESS BENEFIT

The Covered Person will receive an additional benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if the Covered Person's Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of the application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person’s

certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses his entitlement to such medical assistance, within the 24 month period, his coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
    (a) provide continuation of the benefits contained in this Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:

(a) the conversion coverage provided under item (1) above; or
(b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to

us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan G

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of

The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN G

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of

Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B EXCESS BENEFIT

The Covered Person will receive an additional benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if the Covered Person's Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be

entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if he provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan K

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 50% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit Part A & B

- This Plan pays 50% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits Part B

- This Plan pays 50% of the cost sharing of Medicare Eligible Expenses for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has

	been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 50% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**4,140**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person

described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist,

occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN K

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 50% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay 50% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, until the Out of Pocket Limit has been met, then 100%.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 50% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After the Covered Person has reached the Out of Pocket Limit shown on the Schedule, the Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90

days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date

of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the

Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan L

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 75% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit Part A & B

- This Plan pays 75% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits Part B

- This Plan pays 75% of the cost sharing of Medicare Eligible Expenses for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 75% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has

	been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 75% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**2,070**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person

described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist,

occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN L

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 75% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay 75% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, until the Out of Pocket Limit has been met, then 100%.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 75% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 75% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After the Covered Person has reached the Out of Pocket Limit shown on the Schedule, the Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90

days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date

of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the

Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan M

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person’s immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN M

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care

while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person

provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may

also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY

NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan N

Core Benefits

Hospital Benefits Part A	• This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150. • Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.
Blood Benefit Part A & B	• This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.
Medical Benefits Part B	• This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, other than the co-payment amounts shown below, subject to the Medicare Part B Deductible.
• **Office Visit Co-Payment**	• $**[**20**]** per office visit
• **Emergency Room Co-Payment**	• $**[**50**]** per emergency room visit (waived if the Covered Person is admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense)

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.
Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
•	
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN N

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, except as provided in items (3) and (4) that follows.

(3) The Covered Person must pay the lesser of $**[**20**]** or the Medicare Part B coinsurance or co-payment, shown in the Schedule, for each covered health care provider office visit, including visits to medical specialist.

(4) The Covered Person must pay the lesser of $**[**50**]** or the Medicare Part B coinsurance or co-payment, shown in the Schedule, for each visit to an emergency room of a Hospital. This emergency room co-payment will be waived if the Covered Person is admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 100% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be

entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

Medicare Supplement Basics

A Medicare Supplement Insurance plan is a health insurance policy sold by private companies to fill gaps in the original Medicare plan coverage. Medicare Supplement policies must follow federal and state laws. These laws protect you. The front of a Medicare Supplement Insurance policy must clearly identify it as "Medicare Supplement Insurance". You need both Medicare Parts A and B to buy a Medicare Supplement Insurance policy.

The best time to buy a Medicare Supplement Policy is during your open enrollment period.

Your Medicare Supplement Insurance open enrollment period lasts for 6 months. It starts on the first month that you are Medicare eligible. Once the 6-month open enrollment period starts, it cannot be changed. During this period, an insurance company cannot 1) Deny you insurance coverage, 2) Place conditions on a policy (like making you wait for coverage on a policy to start), or 3) Charge you more for a policy because of past or present health problems.
(The open enrollment period for New York State residents lasts indefinitely.)

A Medicare Supplement Insurance plan cannot drop your coverage.

Because your Medicare Supplement Insurance policy is guaranteed renewable (a right that requires your company to automatically renew or continue your Medicare Supplement Insurance policy), your coverage cannot be dropped unless you do not pay your premium or make a material misrepresentation.

You will never be singled out for a rate increase based solely on your age or change in health. Your premium will only be raised if it is raised for all certificates in your class in your state.

What You Should Know

Be sure to take a look at the company behind the plan. Consider the excellent service which is available, toll-free from courteous and highly trained customer service representatives, as well as timely payment of your claims. You'll also want to consider the superior reputation of the underwriter of your coverage. The more confident you feel in the company behind the plan, the more confident you will feel in your decision to apply now.

The Transamerica Value

When you select a Transamerica Medicare Insurance Supplement Plan, you receive more than just a great plan at a great rate. You also get a great value.

- **Freedom of choice.** You have a wide range of standardized plans to consider. And freedom to choose your own doctors, hospitals and specialists.
- **Great service when you need it.** Our courteous and expert customer service representatives are ready to help. We are just a phone call away. Call us for quick and reliable answers to your questions.
- **Fast and easy claims payment.** To help you make the most of your plan benefits no claim forms are needed for payment. Claims are processed quickly too, with 98% of covered claims being paid within [7-10] business days.* And with our electronic filing your Part B claims are processed automatically. There's no paperwork for you or your healthcare provider.

  * The source of the claims statistics is based on an internal survey of Transamerica Life Insurance Company's claims processing experience as of [2009].

Financial Strength

Through our financial strength you get additional peace of mind. The underwriters of this plan, Transamerica Life Insurance Company and Transamerica Financial Life Insurance Company (for New York Residents), both AEGON companies, are rated A (Excellent) by A.M. Best Company, the nation's leading rating service on the financial health of insurance companies sine 1899. This is A.M Best's [3rd highest rating out of 16]. A.M. Best last affirmed this rating on [April 23, 2009]. For additional ratings information access www.ambest.com. Underwritten by Transamerica Life Insurance Company under Policy MS8000GPT and Transamerica Financial Life Insurance Company (for New York Residents) under Policy AUSAGP4400MG. Note: This Medicare Supplement plan for Transamerica Life Insurance Company (Transamerica Financial Life Insurance Company for New York Residents) is not connected with or endorsed by the U. S. Government or Federal Medicare Program.

You've earned the privileges that come with high-quality protection at an affordable group rate. It's easy to apply. Simply complete and mail your application today!

Transamerica Life Insurance Company – Home Office: Cedar Rapids, Iowa
Transamerica Financial Life Insurance Company – Home Office: Purchase, New York

[Legal Code - AEGON]

Finally, Medicare Supplement Insurance Protection with the privileges you deserve!

TRANSAMERICA® LIFE INSURANCE COMPANY

TRANSAMERICA® FINANCIAL LIFE INSURANCE COMPANY

FOR NEW YORK RESIDENTS

MSBRO2010

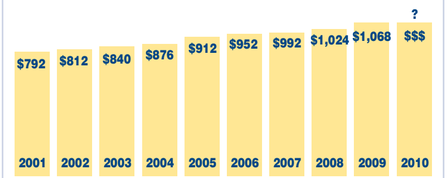
You've earned your Medicare Benefits.

Medicare was created in 1965 to help Americans age 65 and over and those with disabilities pay for hospital and medical expenses. Medicare has Hospital Insurance (referred to as Part A) and Medical Insurance (referred to as Part B). Part A helps to pay for your in-hospital expenses, care in a skilled nursing facility, and provides limited benefits for home health care and hospice care. Part B helps to pay doctor bills, outpatient hospital care and other medical services not covered by Part A.

Medicare does not cover all of your costs.

Medicare was never intended to pay all health care costs for its beneficiaries, and it still does not. In fact, with Medicare coverage alone, you could be exposed to thousands of dollars in costs that you could have to pay. That's why many people have opted to get Medicare Supplement Insurance (Medigap) Protection to help pay for out-of-pocket expenses.

Each and every year since Medicare began, out-of-pocket costs have increased. Here's how Medicare has raised the Part A deductible over the past 10 years:



With quality Medicare Supplement Insurance Protection, you'll have coverage designed to keep pace with these ever-increasing costs. Each year, your coverage will be automatically updated to help keep pace with the increased costs that Medicare passes on to you.

Some Examples of Gaps in Medicare-covered Services

What YOU Pay in [2009] (These amounts can change each year)	A Medigap policy may help pay these costs
Hospital Stays For each benefit period, YOU PAY • [$1,068] for the first 60 days • [$267] per day for days 61-90 • [$534] per day for days 91- 150 (while using your 60 lifetime reserve days)	✔
Skilled Nursing Facility Stays For each benefit period, YOU PAY • Nothing for the first 20 days • Up to [$133.50] per days 21-100	✔
Blood **YOU PAY** the cost of the first three pints	✔
Medicare Part B Yearly Deductible **YOU PAY** the [$133.50] per year deductible	✔
Medicare Part B Covered Services YOU PAY • 20% of the Medicare-approved amount for most covered services • 50% of the Medicare-approved amount for outpatient mental health treatment* • Copayment for outpatient hospital services	✔

*"2009 Choosing a Medigap Policy" - Centers for Medicare and Medicaid Services.

You need to fill in the gaps and protect your retirement income.

This Medicare Supplement is standardized coverage, which meets all Federal and State Guidelines. The supplemental coverage is designed to help fill the gaps left by your Medicare coverage. Applying for this affordable Medicare Supplement coverage is also a good way to help protect your retirement income, as well as the savings you've accumulated over the years. Please refer to the enclosed benefit charts for the plan that best suits your needs.

- **You'll have a wide choice of standardized plans to consider.**

  This high quality Medicare supplement program makes a variety of plans available to meet your needs and fit your budget. Please see the enclosed plan overviews for detailed information on benefits.

- **You'll have affordable group-rated coverage.**

  Your group rates under the group plan are not available to the general public. This allows you to take advantage of the group buying power of the organization you belong to.

- **You are in control.**

  With this Medicare Supplement insurance protection, you can go to any doctor, hospital, or other health care provider of your choice.

- **You'll have quick answers when you need them.**

  Should you have a question, simply call our toll-free service line at [1-800-247-1771 between Monday through Friday, from 8:00 a.m. to 6:00 p.m., Eastern Time], for the answers you need.

- **You'll receive fast payment of claims with no hassles and no paperwork.**

  To help you make the most of your plan benefits no claim forms are needed for payment. Claims are processed quickly too, with 98% of covered claims being paid within [7-10] business days.* And with our electronic filing your Part B claims are processed automatically. There's no paperwork for you or your healthcare provider.

*The source of the claims statistics is derived from Transamerica's business experience.

It's easy to apply. Simply complete and mail your application today!

Satisfaction Guaranteed

Review your Certificate of Coverage for 30 days. We think you'll be happy with your coverage. If you are not completely satisfied, return it for a full refund – no questions asked!

IMPORTANT:

- **Some Medicare-related programs DO NOT allow complete freedom of choice.**
- **This program DOES PROVIDE you with the freedom to choose any doctor or specialist.**

Questions?

Call toll-free, 1-800-247-1771.

Monday – Friday, 8:00 a.m. to 6:00 p.m., Eastern Time.

Our customer service associates are available to answer any questions you may have.

These Plans are underwritten by Transamerica Life Insurance Company, Transamerica Life, a member of the AEGON Group Companies, is rated ["A" (Excellent 3rdof 16 rating)] by A. M. Best Company as of [4/5/09] independent analysts of the insurance industry. This rating attests to the company's financial strength and operating performance Transamerica Life is rates ["AA -" (Very Strong)] by Standard & Poor's Insurance Rating Services as of [3/31/09]. This rating refers to their financial strength.

Right to Renew Your Protection

Your protection under these Medicare Supplement Plans is renewable, as long as you pay your premiums when due.

Pre-Existing Conditions

No benefits will be provided during the first six (6) months, (3 months in WA and WY) from the effective date of coverage for any sickness or injury for which you were treated or advised by a physician during the six (6) months (3 months in MN, WA, and WY) prior to the effective date of coverage.

If this coverage replaced creditable coverage that has been in force within the past sixty-three (63) calendar day (90) in ME and WY), then this pre-existing conditions limitations will be waived to the extent that it was satisfied under the prior creditable coverage. This waiver will apply only to prior creditable coverage which includes, but is not limited to coverage under a group health plan, health insurance coverage, Medicare Supplement Insurance, Medicare Part A and B, Champus/TRICARE, a state health benefits risk pool or the Federal Employees Health Benefits Plan (FEHB).

Exclusions

This plan does not cover any expenses that are not Medicare eligible expenses, except as other wise specified.

We have attempted to explain clearly and briefly the benefits available to you under the Medicare Supplement Insurance Plans. All the provisions of the Plans are contained in the Certificate underwritten by Transamerica Life Insurance Company, Home Office: Cedar Rapids, IA. The Policy, MS8000GPT, is governed by the laws of your state. Since the Policy is complete in detail, the final interpretation of any provision of claim is governed by it. This Medicare Supplement Insurance Plan is not connect with or endorsed by the U. S. Government or Federal Medicare Program.

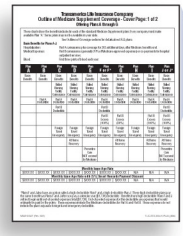
Administrative Office:
Transamerica Life Insurance Company
Direct Response Division
300 Eagleview Blvd.
Exton, PA 19341-1191

[Sample A. Sample]
You will find enclosed for your convenience

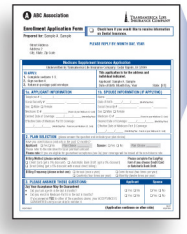
A personal letter with important details on the Medicare Supplement Insurance Protection now available to you through this group plan.

A color brochure highlighting some of the "Transamerica advantages" you can enjoy with this high-quality protection.

Answers to frequently asked questions regarding Medicare Supplement Protection.



An Outline of Coverage is enclosed.



Your Application Form. Be sure to fully complete the application and sign.

You will receive your Certificate along with your identification card, and details on how to make the most of your plan benefits once you are accepted. You'll also begin receiving your FREE quarterly newsletter filled with helpful information and health related tips.

Thank you for your careful consideration of this valuable Medicare Supplement Insurance Protection. We look forward to serving your needs!

Underwritten by:
Transamerica Life Insurance Company,
Transamerica Financial Life Insurance Company
For New York Residents

Any Questions? Call 1-800-749-6983

8:30 a.m. to 6:00 p.m., Eastern Time

[ABC Association logo][A]

TRANSAMERICA LIFE INSURANCE COMPANY

C

[Sample A. Sample
123 Main Street
Anytown, U.S. 12345-6789][B]

D

[[To guarantee rates for [12] [months]], Please respond by [date].
[Lock-in your rates for [1] [full year].]]
[You can choose your own physicians and lock-in rates [for one full year.]][for your current age.]]
[Lock-in your rate and save.]
[Here's the information [we promised][promised by [ABC Association][1]!
[It's <u>your right</u> to have Medicare Coverage. It's <u>our privilege</u> to provide you with valuable options to help cover what Medicare doesn't.]
[Important: Second Notice]
[It's <u>not too late [to secure your coverage].</u> [Apply][Enroll] today.] [You can still make sure you're prepared for thousands of dollars in medical expenses that Medicare doesn't cover.]
[IMPORTANT: Please [apply][enroll] <u>before</u> your [65th] birthday.
[Don't wait to find out what Medicare doesn't cover.]
[Your [65th] birthday is fast approaching. [But it's not too late to [apply][enroll] in our Medicare Supplement Insurance Plan.]
[And it PAYS to find out what Medicare doesn't cover before you get left with unpaid medical bills.]
[Urgent Last Reminder:]
[It's not too late to make sure you are prepared for the thousands of dollars in uncovered expenses with Medicare.]
[Guaranteed Acceptance when you [apply][enroll] during Open Enrollment.]

Dear [Sample A. Sample][B,]

I.A

Thank you for your interest in the <u>[ABC Association][1] [endorsed][2] Medicare Supplement Insurance Protection</u>. You made a wise decision to learn more about the valuable coverage options through Transamerica Life Insurance Company. [During the time that we have worked with them,][[ABC Association][1] has found Transamerica Life Insurance Company to provide exceptional customer service and to offer outstanding value to our [members][3]].

I.B

As your 65th birthday comes closer, you'll need to make some very important decisions about your health care coverage. And because you're a valued [ABC Association] [1] [member] [3], we want to offer some help.

I.C

As you probably know, Medicare can be a big help in coping with ever-increasing medical costs on a retirement budget. But it by no means covers everything. That's why I'm writing you today. [The] [ABC Association][1] [endorsed][2] Medicare Supplement Insurance from Transamerica Life Insurance Company can help. It can pay up to 100% of eligible deductibles and co-payments, so you're covered for things like medical tests, hospital stays, outpatient benefits, and emergency care.

Even with Medicare, you may be surprised at what you have to pay.

The fact is, Medicare was never intended to pay all health care costs for its beneficiaries, and it still doesn't. With the co-payments and the deductibles for hospital costs, doctor visits and other medical services Medicare doesn't cover, you could find yourself left with hundreds, or even thousands of dollars in expenses to be paid out of your own retirement savings. That's why many people have opted to get Medicare Supplement Insurance protection to help pay for out-of-pocket expenses.

Now that you're enrolling in Medicare, you should be aware: it's certainly helpful in paying for hospital and medical costs, but it does not cover all of the costs you could be responsible to pay.

I.D

Be prepared for what you could have to pay out of your own retirement income or your savings once you turn age [65].

The fact is, Medicare was never intended to pay all health care costs for its beneficiaries, and it still doesn't. With the co-payments and the deductibles for hospital costs, doctor visits and other medical services Medicare doesn't cover, you could find yourself left with hundreds, or even thousands of dollars in expenses to be paid out of your own pocket.

Now you can receive up to 100% paid-in-full protection for your Medicare co-payments and deductibles.

Based on the [ABC Association] [1] [-endorsed][2] Medicare Supplement Insurance Plan you select from Transamerica Life Insurance Company, it can provide up to 100% PAID IN FULL coverage for your deductibles and co-payments. This important coverage helps with medical tests, hospital stays, outpatient benefits, and emergency care.

If you haven't already [enrolled][applied], now is the time to act. While Medicare helps with hospital and medical expenses, it was simply never designed to pay for everything.

The fact is you could be left to pay thousands of dollars in expenses out of your own retirement income and savings. That's why many people get Medicare Supplement Insurance Protection to pay for out-of-pocket expenses. Why put your savings and retirement plans at risk?

I.E

Receive up to 100% payment for your Medicare co-payments and deductibles.

I recommend careful consideration of the [ABC Association] [1] [endorsed][2] Medicare Supplement Insurance from Transamerica Life Insurance Company. This quality Medicare Supplement Insurance protection is designed to help pay the expenses Medicare doesn't. It can pay you up to 100% of eligible deductibles and co-payments, so you're fully covered for things like medical tests, hospital stays, outpatient benefits, and emergency care.

I.F

As you know, it's your right to have Medicare coverage, and you've earned the benefits that it provides. However, as you're already aware, Medicare does not cover all of your hospital and medical expenses. Secure [ABC Association] [1] [endorsed][2] Medicare Supplement Insurance Protection from Transamerica Life Insurance Company to help protect yourself from up to thousands of dollars in uncovered medical expenses.

I.G

Enclosed is the information you requested on [DATE]. We appreciate your interest in the [ABC Association] [1] [endorsed][2] Medicare Supplement Insurance Protection.

I.H

So you're turning [65]. Congratulations on reaching this milestone in your life.

[ABC Association][1] recognizes that you've earned the right to a number of privileges [for your military service] whether you've decided to sit back and relax, spend more time [traveling][11] [in your RV] or even extending your career.

Turning [65] also brings with it the need to make some important decisions. One of those is deciding how to handle your health care.

I.I

Sure you qualify for Medicare, but as good as Medicare is, it does NOT pay all your bills. In fact, with just Medicare alone you could be left to pay thousands of dollars in health care costs out of your own pocket. That is where the [ABC Association][1] comes in. We've worked hard to design a plan to help you maximize your Medicare benefits.

We are pleased to offer [ABC Association][1] [endorsed][2] Medicare Supplement Insurance Plans, underwritten by Transamerica Life Insurance Company. These plans are designed to supplement the benefits paid by Medicare. They pay in addition to whatever Medicare covers.

II.A

The [ABC Association][1] believes in these plans and that they may help you save money: These plans are offered at affordable group rates that are not available to the general public. One of the main reasons people join [clubs [and associations]][12] is to gain real savings on essential insurance plans. The [ABC Association][1] is pleased that they've come through for you here.

- Save an additional [5%] off your [monthly][5] rate when you select the [EasyPay] [monthly][5] payment plan. With [EasyPay] your payment will be forwarded automatically by your bank.

II.B

We're writing you today to tell you about Medicare Supplement plans, underwritten by Transamerica Life Insurance Company designed to comply with the Medicare Supplement insurance regulations adopted by your state.

II.C

Enclosed are the Medicare Supplement plans [endorsed][2] by the [ABC Association][1]. They are underwritten by Transamerica Life Insurance Company. These insurance plans have been designed to comply with Medicare Supplement insurance regulations adopted by your state.

II.D

Receive up to 100% payment for your Medicare co-payments and deductibles.

With [the] [ABC Association][1] [-endorsed][2] Medicare Supplement Insurance from Transamerica Life Insurance Company, you can have the help you need. This coverage can pay you up to 100% of eligible deductibles and co-payments, so you're covered for things like medical tests, hospital stays, outpatient benefits, and emergency care.

II.E

[You can choose from a variety of plans to best fit your needs and budget. [The ABC Association][1] [We] recommend[s] Plan[s] [A], [C], [F][and] [G][4]. Here's a quick look at the affordable [monthly][5] rates for those plans in [State][B,]

[Just look at these affordable [monthly][5] rates for [State][B] residents. [We] [The] [ABC Association][1] think[s] you'll see that they provide great value for the money.]

Plan [A][4]	**Plan [C][4]**	**Plan [F][4]**	**Plan [G][4]**
$X.XX[B]	**$X.XX[B]**	**$X.XX[B]**	**$X.XX[B]**

[Rates above include a 5% Smart Rewards billing discount [for prepaying your premium through [annual direct bill payment[[or][EasyPay][Bank Account or Credit Card payment.]] [Rates above are for a non-smoker/non-tobacco user and include a 5% Smart Rewards billing discount [for prepaying your premium through [annual direct bill payment[[or][EasyPay][Bank Account or Credit Card payment.]][10]

II.F

[You made a wise decision to learn more about the valuable coverage options through Transamerica Life Insurance Company.] When you select a Transamerica Life Insurance Company Medicare Supplement Plan you receive more than just a great plan at a great rate.

You also get the Transamerica Value.

II.G

Your benefits extend far beyond these affordable group rates with [ABC Association][1] [endorsed][2] Medicare Supplement Insurance plans. Sign up now and you'll also enjoy these outstanding features:

- **Peace of mind.** You will never be singled out for a rate increase based solely on your age or change in health.
- **Freedom of choice.** You have a wide range of standardized plans to consider. And freedom to choose your own doctors, hospitals and specialists.
- **Great service when you need it.** Our courteous and expert customer service representatives are ready to help. We are just a phone call away. Call us for quick and reliable answers to your questions.
- **Fast and easy claims payment**. To help you make the most of your plan benefits no claim forms are needed for payment. Claims are processed quickly too with [98%][6] of covered claims being paid within [5] [6] business days. And with our electronic claims filing, your Part B claims are processed automatically. There's no paperwork for you or your healthcare provider.
- **Stability.** Transamerica Life Insurance Company has the financial strength and track record that you can rely on. Transamerica will be there for you.

III.B

You can save with Smart Rewards.

With Smart Rewards, you can enjoy savings year after year. When you plan your payments ahead, you can save with the [annual pay, bank draft, or credit card][9] payment discounts. What's more, if you don't smoke or use tobacco, you will receive a special discount off our standard Medicare Supplement rate. When you continue to live smart and plan smart, you can continue to enjoy these Smart Rewards, which can add up to thousands of dollars in savings.

III.C

You can save with Smart Rewards.

With Smart Rewards, you can enjoy savings year after year. When you plan your payments ahead, you can save with the [annual pay, bank draft, or credit card][9] payment discounts.

III.D

So how do you decide which coverage is best for you?

Easy…compare insurance companies. That's when you discover that there are certain things that are not standardized-such as the service you get and the company behind the plan.

The [ABC Association][1] has selected Transamerica Life Insurance Company as the underwriter of their program because they have the kind of financial strength and track record that you can rely on. Whether you are making a claim for benefits or simply have a question, we think that you'll be impressed with the service behind the plan. Best of all, you'll have the security of knowing your coverage is backed by the [ABC Association][1] seal of approval.

Your satisfaction is guaranteed – or your money back.

Once you receive your Certificate of Coverage, you will have 30 days to review it. If you are not completely satisfied, return it for a full refund – no questions asked[!][.]

Take advantage of quality coverage, affordable group rates, plus the additional savings of Smart Rewards. Apply now with a money-back guarantee. Simply complete and return the [Enrollment][Application] form enclosed. If you are not completely satisfied, you'll be under no further obligation. If you have any questions, call [ABC Administrator][Customer Service at][**1-800-749-6983** from 8:30 a.m. to 6:00 p.m., Eastern Time, Monday through Friday][7].

[Sincerely][Best Regards][Semper Fi],

Signature
Name, Title
[ABC Association]
[Plan][Program] [Administrator]

1

E

[P.S. – You made a wise decision to learn more about the valuable Medicare Supplement options available to you through [ABC Association][1] [endorsed][2] Transamerica Life Insurance Company plans. I urge you to apply today[!][.]]

[P.S. Don't miss your chance to secure affordable group-rated coverage with the [ABC Association][1] [endorsed][2] Medicare Supplement Plan of your choice. Apply today!]

[P.S. I urge you to consider the financial advantages of securing this affordable supplemental protection. Apply today at no risk!]

[P.S. [Apply][Enroll] today so your benefits will be in place when you turn [65], plus you'll be locked in at a lower rate. SO ACT NOW!]

[P.S. – Please apply by the date indicated on your [application][enrollment] form. We don't want you to miss your chance to get valuable [ABC Association][1] [endorsed][2] Medicare Supplement Insurance Protection to help protect yourself from the many expenses that Medicare doesn't cover.]

[P.S. [ABC Association][1] encourages you to read carefully the materials in this packet. If you have questions or would like assistance with your application, please call [Transamerica Life Insurance Company][ABC Administrator] at [**1-800-xxx-xxxx**]. We will be happy to help.]

1

[To [enroll][apply] by phone call [**1-800-xxx-xxxx** from 8:00 a.m. to 6:00 p.m., Eastern Time, Monday through Friday][7]. To [enroll][apply] online visit our website [www.abcdefghijk].

A[Medicare Supplement Insurance: is not a deposit; is not insured by the [FDIC][NCUA]; is not guaranteed by [Bank Institution Name] or an affiliated insured depository institution.][8]

Note: This Medicare Supplement Insurance plan is not connected with or endorsed by the U.S. Government or Federal Medicare Program.

Transamerica Life Insurance Company – Home Office: Cedar Rapids, Iowa

Medicare Supplement Insurance Protection
Answers to Frequently Asked Questions

[April 2010]ž [Volume 1, Issue 1]

Choosing Your Plan

Q. What are the most popular plan choices?

A. Plans A, C, and F are the most popular plan selections. Plan A is the basic plan and is the least expensive plan available. Plan C offers more coverage than Plan A, and it may be a good option for you if your doctors accept Medicare as payment in full for a covered charge. Plan C also includes coverage for home health care and provides emergency care benefits for travel outside the United States. Plan F also provides coverage for home health care and for travel outside the United States. It may also be a better option if you use doctors who do not accept Medicare assignment.

Q. What are group rates?

A. Your rates under the group plan are not available to the general public. This allows you to take advantage of the group buying power of the organization you belong to. This group purchasing power can be factored into the underwriting company's ability to keep your rates affordable. With a group plan you will never be singled out based on your individual age and health.

Q. Who do I call when I have a question?

A. Excellent customer service is available to you from courteous and expert customer service representatives who are ready to help. We are ready to answer your questions. We know your time is valuable. Anytime you have a question, simply call our toll-free customer service line for the answers you need.

Q. Will my insurance rate increase as I grow older?

A. Under state law, your individual age is not a factor in your insurance rates. You will never receive a rate increase just because you grow older. And you will never be singled out for a rate increase because of the number of claims you send in. Any rate change will apply to all members of the same class insured under your plan who reside in your state.

Using Your Benefits

Q. How will my claims be handled?

A. To help you make the most of your plan benefits no claim forms are needed for payment. Claims are processed quickly too, with 98% of covered claims being paid within 7-10 business days. And with our electronic filing your Part B claims are processed automatically. There's no paperwork for you or your healthcare provider.

Q. Can I see any doctor or specialist I want with this coverage?

A. Yes, you have complete freedom of choice with your coverage. You can go to any doctor, hospital, or specialist of your choosing. There

(Over, please)

Take Advantage of the Transamerica Value.
Return your application today!

is no set provider list of doctors or hospitals that will restrict your coverage in any way as long as the provider accepts Medicare assignment.

Q. Am I protected when I'm away from home?

A. Yes, you can use your Medicare Supplement coverage anywhere in the United States. If you are planning to travel outside of the United States, you will want to select a plan that covers foreign travel, such as Plan F.

Q. If I purchase a plan now, can I change my mind?

A. Yes, you can apply for this coverage today at no risk to you. In fact, you'll have a full 30-day satisfaction guarantee. If you are not 100% satisfied when you receive your Certificate of Insurance, simply return it within 30 days, no questions asked. You will be under no further obligation.

Assuring Your Protection

Q: What is the financial rating of the insurance underwriter?

A: Transamerica Life Insurance Company is awarded an [A (Excellent)] rating from A.M. Best for financial strength and operating performance and an [AA- (Very Strong] rating from Standard & Poor's insurance rating service for financial strength. Ratings and Analysis for [2009].

Q: What are Medigap Protections?

A: By law, you have the right to buy a Medigap (Medicare Supplement) policy if you lose certain types of health care coverage. Without these protections insurance companies can refuse to sell you an insurance plan or charge you a higher premium if you have health problems. Also if you drop your Medicare Supplement policy, you may not be able to get it back except in very limited circumstances.

For example, you may have a right to buy a Medicare Supplement policy if:

- Your Medicare Advantage plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area.
- You move out of the service area of your Medicare Advantage provider.

Q: Can my Medicare Supplement Insurance plan be dropped or cancelled?

A: Your insurance cannot be cancelled....no matter what your age or health, or because of how many claims you may have. Your protection under these Medicare Supplement Plans is guaranteed renewable, as long as you have not made a material misrepresentation and pay your premiums when due, you will own this insurance for life. Even if the group discontinues their participation in this plan, you are guaranteed that your coverage will continue.

TRANSAMERICA LIFE INSURANCE COMPANY

Questions? Call toll-free, 1-800-749-6983

Monday • Friday, 8:00 a.m. to 6:00 p.m., Eastern Time.

[ABC]
Medicare Supplement Insurance Plans

Underwritten by

Transamerica Life Insurance Company
[Rated [“A” (Excellent] by A.M. Best Company]
[Rated [“AA-” (Very Strong)] by Standard & Poor’s]
[Rated [“A1” (Good)] by Moody’s]
[Rated [“AA” (Very Strong)] by Fitch]
Sample A. Sample

1. Your monthly premium when you enroll by the respond by date: Date

	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan MI	Plan N
Non-Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX
Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX

2. Your monthly premium when you also sign-up for Smart Rewards with a discount for prepaying your premium through Annual Direct Bill Payment or EasyPay (Bank Account or Credit Card).

	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan M	Plan N
Non-Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX
Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX

IMPORTANT RATE GUARANTEE: If You apply by the respond by date, these rates are GUARANTEED NOT TO INCREASE for one full year from your effective date of coverage.

State: ST
Rate Effective Date: Month/Day/Year

[ABC]
Medicare Supplement Insurance Plans

Underwritten by

Transamerica Life Insurance Company
[Rated [“A” (Excellent)] by A.M. Best Company]
[Rated[“AA-” (Very Strong)] by Standard & Poor’s]
[Rated [“A1” (Good)] by Moody’s]
[Rated [“AA” (Very Strong)] by Fitch]

For Spouse of
Sample A. Sample

3. Your monthly premium when you enroll by the respond by date: Date

	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan M	Plan N
Non-Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX
Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX

4. Your monthly premium when you also sign-up for Smart Rewards with a discount for prepaying your premium through Annual Direct Bill Payment or EasyPay (Bank Account or Credit Card).

	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan M	Plan N
Non-Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX
Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX

State: ST
Rate Effective Date: Month/Day/Year

[ABC]
Medicare Supplement Insurance Plans

Underwritten by

Transamerica Life Insurance Company
[Rated ["A" (Excellent] by A.M. Best Company]
[Rated ["AA-" (Very Strong)] by Standard & Poor's]
[Rated ["A1" (Good)] by Moody's]
[Rated ["AA" (Very Strong)] by Fitch]
Sample A. Sample

1. Your monthly premium when you enroll by the end of your [65th] birth month.

	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan M	Plan N
Non-Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX
Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX

2. Your monthly premium when you also sign-up for Smart Rewards with a discount for prepaying your premium through Annual Direct Bill Payment or EasyPay (Bank Account or Credit Card).

	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan K	Plan L	Plan M	Plan N
Non-Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX
Tobacco	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX	$XXX.XX

IMPORTANT RATE GUARANTEE: If You apply by the respond by date, these rates are GUARANTEED NOT TO INCREASE for one full year from your effective date of coverage.

State: ST
Rate Effective Date: Month/Day/Year

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Rate Information

Rate data applies to filing.

Filing Method: Prior Approval
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Transamerica Life Insurance Company	%	%				%	%

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 09/30/2009	Arkansas Rate Sheet	MS8000GPT	New		Arkansas Rates.PDF

Exhibit A

Transamerica Life Insurance Company

Standard Group Medicare Supplement
State of Arkansas
Monthly Premium Rates

Non-Smoker

Composite Age	Plan A-2010	Plan B-2010	Plan C-2010	Plan D-2010	Plan F-2010	Plan G-2010	Plan K-2010	Plan L-2010	Plan M-2010	Plan N-2010
All Ages	120	161	191	177	192	177	88	131	161	151

Smoker

Composite Age	Plan A-2010	Plan B-2010	Plan C-2010	Plan D-2010	Plan F-2010	Plan G-2010	Plan K-2010	Plan L-2010	Plan M-2010	Plan N-2010
All Ages	132	177	210	194	211	195	97	144	177	166

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	09/30/2009

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

		Item Status:	Status Date:
Satisfied - Item:	Application	Accepted for Informational Purposes	09/30/2009

Comments:

See Forms Schedule Tab

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Accepted for Informational Purposes	09/30/2009

Comments:

See Forms Schedule Tab

		Item Status:	Status Date:
Satisfied - Item:	AR Cover Letter MS8000	Accepted for Informational Purposes	09/30/2009

Comments:

Attachment:

AR Cover Letter MS8000.PDF

		Item Status:	Status Date:

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Satisfied - Item: Explanation of Variables MS8000

Accepted for Informational Purposes

09/30/2009

Comments:

Attachment:

Explanation of Variables MS8000.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	Explanation of Variables for MS8000GAT	Accepted for Informational Purposes	09/30/2009

Comments:

Attachment:

Explanation of Variables for MS8000GAT.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	Explanation of Variables - MSLTR2010	Accepted for Informational Purposes	09/30/2009

Comments:

Attachment:

Explanation of Variables - MSLTR2010.PDF

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Transamerica Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
MS8000GAT.AR	41
MS8000GCT-A.AR	42
MS8000GCT-B.AR	42
MS8000GCT-C.AR	42
MS8000GCT-D.AR	42
MS8000GCT-F.AR	42
MS8000GCT-G.AR	42
MS8000GCT-K.AR	43
MS8000GCT-L.AR	43
MS8000GCT-M.AR	42
MS8000GCT-N.AR	41
MS8000GOTCS	41
MS8000GPT-A.AR	42
MS8000GPT-B.AR	42
MS8000GPT-C.AR	41
MS8000GPT-D.AR	41

STATE OF ARKANSAS

READABILITY CERTIFICATION

Form Number	Score
MS8000GPT-F.AR	41
MS8000GPT-G.AR	41
MS8000GPT-K.AR	43
MS8000GPT-L.AR	43
MS8000GPT-M.AR	41
MS8000GPT-N.AR	42

Signed: 

Name: Edward G. Weigand

Title: Director, Product Filing, Compliance and Licensing

Date: 7/31/2009

TRANSAMERICA LIFE INSURANCE COMPANY

AN IOWA STOCK COMPANY I ADMINISTRATIVE OFFICES: BALTIMORE, MARYLAND 21201

July 31, 2009

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

NAIC #468-86231; FEIN#: 39-0989781

RE: MS8000GPT-A.AR et al. - Medicare Supplement Insurance Program
Company Filing#: HM AR0050607C01
See Attached List of Forms

Dear Commissioner Bradford:

The above referenced forms are being submitted for your review and approval. These forms are new and in compliance with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) will replace previously approved forms MS4500GPT-A.AR et al which were approved by your department on January 25, 2004 under Department File # 27596. Upon approval, these forms will only be issued with an effective date of June 1, 2010 or later.

Other than the changes required to comply with MIPPA, these forms are the same as those filed and approved for form MS4500GPT-A.AR et al. As with our previously approved filing, the group policy will be issued direct in Arkansas or marketed through an out-of-state trust policy and coverage will be marketed to sponsored association groups and financial institutions on a direct response, mass marketed basis.

Included in this submission are: the 10 Standardized Medicare Supplement Insurance Plans A through D, Plans F and G and Plans K through N (we will **not** offer high Deductible Plan F), the required outline of coverage, application, rates and actuarial materials, and advertising material that will be used with this product.

These forms are being filed concurrently in our domicile state of Iowa.

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Sincerely,

Edward G. Weigand
Director, Product Filing & Compliance
(800) 233-4624, ext. 5265
(410) 209-5910 (Fax)
eweigand@aegonusa.com (E-mail)

List of Forms
Group Medicare Supplement Insurance Program

Group Policies:

MS8000GPT-A.AR - Group Medicare Supplement Insurance Policy Plan A
MS8000GPT-B.AR - Group Medicare Supplement Insurance Policy Plan B
MS8000GPT-C.AR - Group Medicare Supplement Insurance Policy Plan C
MS8000GPT-D.AR - Group Medicare Supplement Insurance Policy Plan D
MS8000GPT-F.AR - Group Medicare Supplement Insurance Policy Plan F
MS8000GPT-G.AR - Group Medicare Supplement Insurance Policy Plan G
MS8000GPT-K.AR - Group Medicare Supplement Insurance Policy Plan K
MS8000GPT-L.AR - Group Medicare Supplement Insurance Policy Plan L
MS8000GPT-M.AR - Group Medicare Supplement Insurance Policy Plan M
MS8000GPT-N.AR - Group Medicare Supplement Insurance Policy Plan N

Group Certificates of Insurance:

MS8000GCT-A.AR - Group Medicare Supplement Insurance Certificate Plan A
MS8000GCT-B.AR - Group Medicare Supplement Insurance Certificate Plan B
MS8000GCT-C.AR - Group Medicare Supplement Insurance Certificate Plan C
MS8000GCT-D.AR - Group Medicare Supplement Insurance Certificate Plan D
MS8000GCT-F.AR - Group Medicare Supplement Insurance Certificate Plan F
MS8000GCT-G.AR - Group Medicare Supplement Insurance Certificate Plan G
MS8000GCT-K.AR - Group Medicare Supplement Insurance Certificate Plan K
MS8000GCT-L.AR - Group Medicare Supplement Insurance Certificate Plan L
MS8000GCT-M.AR - Group Medicare Supplement Insurance Certificate Plan M
MS8000GCT-N.AR - Group Medicare Supplement Insurance Certificate Plan N

MS8000GOTCS - Outline of Coverage, Group Plans, A-D, F, G, K-N

MS8000GAT.AR - Application Form

Advertising Forms:

MSBRO2010 – Brochure
MSBKS2010 – Buck Slip
MSLTR2010CS – Solicitation Letter
MSINFS2010 – Information Sheet
MSQA2010CS – Question and Answer Sheet
MSRS2010 – Rate Sheet Page
MSRSBDY2010 – Birthday Rate Sheet Page
MSRSGI2010 – General Inquiry Rate Sheet Page

EXPLANATION OF VARIABLES
Medicare Supplement Insurance Program - MIPPA Compliant Forms

Group Policy Form Series MS8000-GPT, Plans A, B, C, D, F, G, K, L, M, N

Schedule of Benefits

- *Group Policy Number*, *Effective Date*, *Anniversary Date*, and *Policyholder* will change case by case to reflect Policyholder specific data.
- Plan N - Schedule of Benefits will reflect appropriate Medical Benefits Part B Office Visit Co-Payment and Emergency Room Co-Payment amounts. This information will also be reflected in the Plan Benefits provision.

Definitions

- In the definitions of Hospital, Nurse, Physician, and Skilled Nursing Facility, "Christian Science" references will be included if appropriate for and selected by the Policyholder.
- In the definition of Member, information will be included that reflects data and/or description specific to the Policyholder.
- The definition of Policy Month, the period of time may begin on the 1st through the 31st day of the month and may end on the 25th through the last day of the month as agreed to by the Policyholder and us.

Eligibility and Effective Date

- The use of the deferred effective date in the event of hospitalization paragraphs may be deleted as agreed to by the Policyholder and us.

Pre-Existing Condition Limitation

- For selected case issues, the Pre-Existing Condition Limitation may be omitted, as agreed to by the Policyholder and us.
- Other Pre-Existing Condition Limitation time periods are 3/6, 6/3 and 3/3, as agreed to by the Policyholder and us

Premiums

- In the Premium Changes provision, prior written notice of premium change must be at least 31 days and may be more, as agreed to by the Policyholder and us. And the statement regarding payment of the increased premium for premium which has already been paid may be omitted, as agreed to by the Policyholder and us.
- The Unpaid Premium provision may be omitted, as agreed to by the Policyholder and us.

General Provisions

- In the Certificates provision, the time to return the certificate will be at least 30 days and may be more, as agreed to by the Policyholder and us.
- In the Right to Terminate provision, prior written notice of termination must be at least 31 days and may be more, as agreed to by the Policyholder and us.
- The Time Limit on Certain Defenses provision will be removed of there is no Pre-Existing Condition Limitation. And the limitation time period will reflect the Pre-Existing Condition time period (but in no case greater than 6 months), as agreed to by the Policyholder and us.

Group Certificate Form Series MS8000-GCT, Plans A, B, C, D, F, G, K, L, M, N

First Page

- The use of the deferred effective date in the event of hospitalization paragraphs may be deleted as agreed to by the policyholder and us.

Schedule of Benefits

- *Covered Person's Name*, *Policy Number*, *Certificate Number*, *Policyholder*, *Effective Date of Coverage*, [*Mode*] *Premium*, and *Covered Person's Age At Issue* will change case by case to reflect Covered Person specific data.
- Plan N - Schedule of Benefits will reflect appropriate Medical Benefits Part B Office Visit Co-Payment and Emergency Room Co-Payment amounts. This information will also be reflected in the Plan Benefits provision.

Definitions

- In the definitions of Hospital, Nurse, Physician, and Skilled Nursing Facility, "Christian Science" references will be included if appropriate for and selected by the Policyholder.
- The definition of Policy Month, the period of time may begin on the 1st through the 31st day of the month and may end on the 25th through the last day of the month as agreed to by the Policyholder and us.

Pre-Existing Condition Limitation

- For selected case issues, the Pre-Existing Condition Limitation may be omitted, as agreed to by the Policyholder and us.
- Other Pre-Existing Condition Limitation time periods are 3/6, 6/3 and 3/3, as agreed to by the Policyholder and us

Premiums

- In the Premiums provision, the change in premium mode may be omitted.
- In the Premium Changes provision, prior written notice of premium change must be at least 31 days and may be more, as agreed to by the Policyholder and us. And the statement regarding payment of the increased premium for premium which has already been paid may be omitted, as agreed to by the Policyholder and us.
- The Unpaid Premium provision may be omitted, as agreed to by the Policyholder and us.

General Provisions

- The Time Limit on Certain Defenses provision will be removed of there is no Pre-Existing Condition Limitation. And the limitation time period will reflect the Pre-Existing Condition time period (but in no case greater than 6 months), as agreed to by the Policyholder and us.

Explanation of Variability
For Group Application Form #MS8000GAT.AR
Transamerica Life Insurance Company

A	Group logo will vary
B	Applicant information will be personalized – name, date of birth, address and residence will vary. Will include when known.
C	Depending on the type of offer and desire by the administrator we will use "send no money" or "cash with application" wording.
D	For those turning age 65, will read "The plans and rates are good only for the address and individual indicated." For all others will read, "This application is for the address and individual indicated." The difference in wording is that those turning age 65 will have rates included on the application and all others will not.
E	Respond by date will vary
F	For those turning age 65 will read 1. APPLICANT INFORMATION. For all others will read 1a. APPLICANT INFORMATION. The difference in wording is that those who are not turning age 65 will have Spouse application information (1b) included.
G	For applicants who are not turning age 65 or their age is not known.
H	For those turning age 65.
I	Billing frequency and billing method may vary. We may or may not offer Automatic Bank Account withdrawal or Credit Card or only certain combinations of Credit Card providers. Several variations of authorization language are attached and will be used based on the wishes of the administrator.
J	Fraud language will vary by state and will be inserted here. The last fraud language sentence will be used for states that do not require state specific language.
K	Address may vary
L	Telephone number and hours of operation, web address may vary
M	Will insert special offers here such as: • No, I am not interested at this time. Please send me another offer in the future on _____ (indicate date desired). • Please send my spouse an application in the future _____ (indicate date desired). • Check here if you would like to receive additional information on other products and services that may be available to you. • Check here if you would like to receive information on [dental insurance][term life insurance][etc.].
	Note: All reference to the group name and phone number has been bracketed throughout the application since this information varies by group.

Explanation of Variability
For Group Solicitation Letter – Form No. MSLTR2010CS
Transamerica Life Insurance Company

A	Group logo will vary
B	Personalized name and address, state, age and/or rate
C	May or may not be used depending on the wishes of the group
D	Different heading/subject lines will be used depending on initial effort, follow-up, etc.
E	May or may not be used depending on the wishes of the group. Different P.S. may be used depending on initial effort, follow-up, etc.
	Note: All reference to the group name and phone number has been bracketed throughout the letter since this information varies by group.
1	Will vary by group
2	Wording will vary depending on the wishes of the group (i.e. endorsed, sponsored, member, customer, approved, accessible, offered, group, etc.)
3	Wording will vary depending on group (i.e. member, retiree, customer, physician, employee, alumnus/a, parent, etc.)
4	Recommended plans may vary by group
5	Mode shown on letter may vary by group
6	Claims statistics will be periodically updated to reflect turnaround time changes
7	Phone number and hours of operation may change or vary by group.
8	Will use when mailing is being sent to a financial institution group.
9	Payment methods offered may vary.
10	Will be variable based on age of person mailed. Will include wording for non-tobacco/non-smoker when over age 65.
11	Wording will vary depending on the wishes of the group (i.e. traveling, hunting, fishing, gardening, cooking, golfing, volunteering, on your hobbies, etc.)
12	Wording will vary depending on the wishes of the group (i.e. associations, clubs, societies, credit unions, financial institutions, etc.)
I.A	This opening paragraph will be used when addressing persons who are age 65 or older who requested information.
I.B	This opening paragraph will be used when mailing to persons approaching age [65], [66], etc.
I.C	This opening paragraph will be used when mailing to persons approaching a birthday such as age [65], [66], etc.
I.D	This opening paragraph will be used when mailing a second effort to persons approaching a birthday such as age [65], [66], etc.
I.E	This opening paragraph will be used when mailing a final effort to persons approaching a birthday such as age [65], [66], etc.
I.F	This opening paragraph will be used when addressing persons who are age 65 or older who requested information when mailing a final effort.
I.G	This opening paragraph will be used when addressing persons who requested information over the phone and/or when age is unknown.

I.H	This opening paragraph will be used when mailing to persons approaching age [65], [66], etc.
I.I	May or may not be used depending on the wishes of the group.
II.A	Paragraph IIA may or may not be used when mailing any effort depending on the wishes of the group.
II.B	Paragraph IIB or IIC may be used when mailing to persons approaching age 65 depending on the wishes of the group
II.C	Paragraph IIB or IIC may be used when mailing to persons approaching age 65 depending on the wishes of the group
II.D	Paragraph IID to be used when mailing to persons approaching a birthday such as age[65], [66], etc.
II.E	Paragraph IIE to be used when mailing to persons when age is known. Opening will vary depending on the wishes of the group. Paragraph IIE will not be included if age unknown.
II.F	Paragraph IIF to be used when mailing to persons who called for information and/or when age is unknown.
II.G	May or may not be used depending on the wishes of the group.
III.A	This paragraph will be used when mailing to persons approaching age [65], [66], etc. or as an alternative to Smart Rewards paragraphs III. B and III C.
III.B	This paragraph will be used when mailing to persons over age 65.
III.C	Paragraph IIIC to be used when mailing to persons who called for information and/or when age is unknown.
III.D	Paragraph IIID may or may not be used when mailing any effort depending on the wishes of the group.

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/03/2009	Form	Application	09/21/2009	MS8000GAT_AR.PDF (Superceded)
08/03/2009	Form	Plan A Certificate	09/21/2009	MS8000GCT-A_AR.PDF (Superceded)
08/03/2009	Form	Plan B Certificate	09/21/2009	MS8000GCT-B_AR.PDF (Superceded)
08/03/2009	Form	Plan C Certificate	09/21/2009	MS8000GCT-C_AR.PDF (Superceded)
08/03/2009	Form	Plan D Certificate	09/21/2009	MS8000GCT-D_AR.PDF (Superceded)
08/03/2009	Form	Plan F Certificate	09/21/2009	MS8000GCT-F_AR.PDF (Superceded)
08/03/2009	Form	Plan G Certificate	09/21/2009	MS8000GCT-G_AR.PDF (Superceded)
08/03/2009	Form	Plan K Certificate	09/21/2009	MS8000GCT-K_AR.PDF (Superceded)
08/03/2009	Form	Plan L Certificate	09/21/2009	MS8000GCT-L_AR.PDF (Superceded)

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

08/03/2009	Form	Plan M Certificate	09/21/2009	MS8000GCT-M_AR.PDF (Superceded)
08/03/2009	Form	Plan N Certificate	09/21/2009	MS8000GCT-N_AR.PDF (Superceded)
08/03/2009	Form	Plan A Master Policy	09/21/2009	MS8000GPT-A_AR.PDF (Superceded)
08/03/2009	Form	Plan B Master Policy	09/21/2009	MS8000GPT-B_AR.PDF (Superceded)
08/03/2009	Form	Plan C Master Policy	09/21/2009	MS8000GPT-C_AR.PDF (Superceded)
08/03/2009	Form	Plan D Master Policy	09/21/2009	MS8000GPT-D_AR.PDF (Superceded)
08/03/2009	Form	Plan F Master Policy	09/21/2009	MS8000GPT-F_AR.PDF (Superceded)
08/03/2009	Form	Plan G Master Policy	09/21/2009	MS8000GPT-G_AR.PDF (Superceded)
08/03/2009	Form	Plan K Master Policy	09/21/2009	MS8000GPT-K_AR.PDF (Superceded)
08/03/2009	Form	Plan L Master Policy	09/21/2009	MS8000GPT-L_AR.PDF (Superceded)
08/03/2009	Form	Plan M Master Policy	09/21/2009	MS8000GPT-M_AR.PDF (Superceded)

SERFF Tracking Number:	*AEGX-126253189*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*43111*
Company Tracking Number:	*HM AR0050607C01*		
TOI:	*MS08G Group Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08G.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*Medicare Supplement/HM AR0050607C01*		

08/03/2009	Form	Plan N Master Policy	09/21/2009	MS8000GPT-N_AR.PDF (Superceded)

A

ABC Association

TRANSAMERICA LIFE INSURANCE COMPANY

[Enrollment][Application] Form

Prepared For: [Sample A. Sample]

[Street address
Address 2
City, state, zip code]

B

o [Check here to…] [see Explanation of Variability]
[_____ M _____]

E [PLEASE REPLY BY: [MONTH DAY, YEAR]

Medicare Supplement Insurance Protection Application Form
Underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA 52499

TO APPLY:

1. Complete sections 1-3.

2. Sign section 4.

3. Return in [postage-paid][enclosed] envelope. [Send no money.][Include a check for your initial premium payment.] [Please enclose your check for your first premium payment for the Plan you've chosen. Make it payable to [Transamerica Life Insurance Company][ABC Administrator].] C

[This application…] D

Applicant: [Sample A. Sample]

[Date of Birth: [Month XX, XXXX]

State: [ST]

F

[1. APPLICANT INFORMATION] [1A. APPLICANT INFORMATION]

Telephone #: (_____) _____

Social Security #: _____-_____-_____

Sex: o Male o Female [Height ____ Weight _____]

Desired [effective] date of coverage: _____

You may use this application form if you are turning age 65 and first enrolling in Medicare Part B. H

Please fill in the following information found on your Medicare ID Card

MEDICARE HEALTH INSURANCE

Medicare Claim Number_____

Hospital (Part A) Effective Date_____/____(mo/yr)

Medical (Part B) Effective Date_____/____(mo/yr)

Are both Medicare Parts A & B coverage active?

o Yes o No

[1b. SPOUSE INFORMATION (IF APPLYING)] G

Name: _____

Date of Birth: _____/_____/_____ (Month/Day/Year)

Social Security #: _____-____-_____

Sex: o Male o Female [Height ____ Weight _____]

Medicare ID #: _____(Found on your Medicare ID Card)

Desired [effective] date of coverage: __ _____/_____/_____

(Month/Day/Year)

Effective date of Medicare Part B Coverage:_____

(Found on your Medicare ID Card)

2. PLAN SELECTION [(please answer the question and indicate your plan choice)] G

G

Have you used tobacco products in the past 12 months?

Applicant: o Yes o No Plan Choice: _____ **Spouse:** o Yes o No Plan Choice: _____

Please refer to the rate sheet for your premium amount.

Please note: If you are eligible for guaranteed acceptance (see 3a) your coverage will be issued at the non-tobacco rate.

H

I wish to apply for…

Plan A o $XXX.XX **Plan B o $XXX.XX** **Plan C o $XXX.XX** **Plan F o $XXX.XX** **Other_____**

Billing Method: (please select one):

[o Direct Billing [(get a 5% discount with annual direct billing)]

[o Credit Card] [(get a 5% discount)] [o Automatic Bank Draft][Electronic Fund Transfer] [(get a 5% discount)]

I

[Please complete the EasyPay form if you choose Credit Card or Automatic Bank Draft.] [Please complete the APO form if you choose Electronic Fund Transfer.]

Billing Frequency: (please select one)

[o Annual
(once a year)]

[o Semi-Annual
(two times a year)]

[o Quarterly
(four times per year)]

[o Monthly
(twelve times per year)]

G

3. [PLEASE ANSWER THESE QUESTIONS]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. To the best of my knowledge-

H

3. [PLEASE ANSWER THE FOLLOWING QUESTION]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. To the best of my knowledge-

Are you applying during an Open Enrollment Period?* • If you answered YES to the question above, your ACCEPTANCE IS GUARANTEED. • If you answered NO to the question above, please call [1-800-749-6983] for a new application. Medicare Supplement applicants applying for coverage outside of the Open Enrollment or Guaranteed Issue Periods are subject to underwriting. *Open Enrollment means that you will not be denied coverage based on your health if your Transamerica Life Insurance Company Medicare Supplement application is submitted during the six-month period beginning with the first month in which you, at age 65 or older, enroll in Medicare Part B.	Applicant o Yes o No **H**

	Applicant	Spouse
G		
3a. Your Acceptance May Be Guaranteed		
• Did you turn age 65 in the last 6 months?	o Yes o No	o Yes o No
• Did you enroll in Medicare Part B in the last 6 months?	o Yes o No	o Yes o No
• If yes, what is the effective date?_____	_____	_____
If you answered yes to both questions skip to section 4		
3b. Premium Assistance Questions (Questions we are required to ask)		
Are you covered for medical assistance through the state Medicaid program: (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)	o Yes o No	o Yes o No
• Will Medicaid pay your premiums for this Medicare supplement policy?	o Yes o No	o Yes o No
• Do you receive any benefits from Medicard OTHER THAN payments toward your Medicare Part B premium?	o Yes o No	o Yes o No
3c. Replacement Questions – answer <u>only</u> if you are replacing coverage		
What are your dates of coverage under the other policy?	Start_____	Start_____
	End _____	End _____
• **Medicare Advantage**		
a. If you had coverage from any Medicare plan <u>other than</u> the original Medicare within the past 63 days (for example, a Medicare Advantage plan, or Medicare HMO, or PPO) fill in your start and end dates below. If you are still covered under this plan leave "END" blank.	Start_____	Start_____
	End _____	End _____
b. If you are still covered under the Medicare plan,do you intend to replace your current coverage with this new Medicare policy?	o Yes o No	o Yes o No
• **Medicare Supplement**		
a. Was this your first time in this type of Medicare plan?	o Yes o No	o Yes o No
b. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	o Yes o No	o Yes o No
c. Do you have another Medicare supplement policy in force?	o Yes o No	o Yes o No
d. If so, with what company, and what plan do you have? _____		
e. If so, do you intend to replace your current Medicare supplement policy with this policy?	o Yes o No	o Yes o No
• **Other**		
a. Have you had coverage under any other health insurance within the past 63days? (for example, an employer, union, or individual plan)	o Yes o No	o Yes o No
b) If so, with what company and what kind of policy?		

3 d) Health Question	Applicant	Spouse
Within the past 2 years, have you ever: had treatment, been recommended, been hospitalized for, or been advised by any member of the medical profession for Alzheimer's Disease, a liver disease, a kidney disease or disorder?	o Yes o No	o Yes o No
§ **Any person responding yes to this question is not eligible for this plan.**		

4. IMPORTANT. PLEASE READ AND SIGN.

I hereby apply for Medicare Supplement coverage issued by Transamerica Life Insurance Company. I understand that this coverage will not pay benefits for conditions for which I have received medical treatment or advice within the last 6 months prior to the effective date until I have been insured for 6 consecutive months. If this plan replaces creditable coverage, such as Medicare Supplement Insurance or primary hospital and medical reimbursement coverage, that has been in force within the past 63 days, or if I am an Eligible Person* enrolled within 63 days of termination, then this pre-existing conditions limitation will be waived to the extent it was satisfied under the replaced coverage.

J

[AR, DC, LA, ME, NM, OH, and OK Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines or confinement in prison.]

[Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information, concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[Tennessee Residents; It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.]

PLEASE SIGN HERE

Applicant's Signature X _____ Date _____

G [Spouse's Signature (if applying) X_____ Date_____]

PLEASE MAIL YOUR COMPLETED, SIGNED [ENROLLMENT][APPLICATION][FORM] IN THE POSTAGE-PAID ENVELOPE, TO:

[Medicare Supplement Department][ABC Administrator][street address] [city][state][zip] K

[QUESTIONS? PLEASE CALL US AT [1-800-749-6983]
WEEKDAYS FROM [8:30 A.M. TO 6:00 P.M., EASTERN TIME]. We're Here to Help.] L

To apply by phone call [1-800-xxx-xxxx from [8:00 a.m. to 6:00 p.m.], Eastern Time, Monday through Friday]. [To apply on-line visit our website [www.abcdefghijk]. L

Underwritten by Transamerica Life Insurance Company under Group Policy No MS8000GPT

MEDICARE SUPPLEMENT INFORMATION TO CONSIDER
• You do not need more than one Medicare Supplement policy or certificate. • If you purchase this certificate, you may want to evaluate your existing health coverage and decide if you need multiple coverages. • You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy or certificate. • If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement certificate can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent policy or certificate) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. • If you are eligible for, and have enrolled in a Medicare supplement certificate or policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement certificate or policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement certificate or policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent certificate or policy) will be resinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement certificate or policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. • Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	**[**JOSEPHINE SAMPLE**]**
[Policy:	**[**MZ0000000H0000A**]]**
[Certificate Number:	**[**SAMPPROD**]]**
[Policyholder:	**[**ABC ASSOCIATION**]]**
[Effective Date of Coverage:	**[**January 01, 2010**]]**
[[Semi-Annual**]** Premium:	**[**$50.00**]]**
[Covered Person's Age At Issue:	**[**65**]]**

Supplemental Medicare Expense Benefits
Plan A

Hospital Benefits **Part A**	• This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150. • Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.
Blood Benefit **Part A & B**	• This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.
Medical Benefits **Part B**	• This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of

any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;

(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN A

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you

are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time

written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan B

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:

(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;

(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN B

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan C

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;

(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN C

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan D

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;

(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN D

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A

Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group

health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Schedule Page (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Schedule Page. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan F

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the **[**Certificate Schedule**]**.

SICKNESS means an illness or disease, which **[**first**]** manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN F

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

MEDICARE PART B EXCESS BENEFIT

You will receive an additional benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if your Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the **[**Certificate Schedule**]** , before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the **[**Certificate Schedule**]** . Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the **[**Certificate Schedule**]** .

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of the application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
   (a) provide continuation of benefits contained in the Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:

(a) the conversion coverage provided under item (1) above; or
(b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to all Covered Persons covered under the Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your **[**Certificate Schedule**]** . **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan G

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN G

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B EXCESS BENEFIT

You will receive an additional benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if your Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan K

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 50% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit
Part A & B

- This Plan pays 50% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits
Part B

- This Plan pays 50% of the cost sharing of Medicare Eligible Expenses, for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 50% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 50% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**4,140**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN K

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 50% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay 50% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for you, until the Out of Pocket Limit has been met, then 100%.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 50% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
You will receive a benefit when we receive proof that, while insured, you incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After you have reached the Out of Pocket Limit shown on the Certificate Schedule, you will receive benefits when we receive proof that, while insured, you incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Certificate Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan L

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 75% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit
Part A & B

- This Plan pays 75% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits
Part B

- This Plan pays 75% of the cost sharing of Medicare Eligible Expenses, for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 75% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 75% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**2,070**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for

Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN L

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 75% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay 75% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for you, until the Out of Pocket Limit has been met, then 100%.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 75% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 75% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT

After you have reached the Out of Pocket Limit shown on the Certificate Schedule, you will receive benefits when we receive proof that, while insured, you incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Certificate Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium

mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan M

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;

(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN M

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you.

If you discontinue or lapse your Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A

Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group

health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
  (a) provide continuation of benefits contained in the Policy; or
  (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
  (a) the conversion coverage provided under item (1) above; or
  (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for two years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499

In this Certificate, Transamerica Life Insurance Company will be called we, our, or us. This Certificate summarizes certain provisions of the Policy. All coverages and provisions are subject to those in the Policy issued to the Policyholder.

We certify that, subject to the terms of the Policy, the Covered Person named in the Certificate Schedule (referred to as you, your, and yours) is insured for the benefits described in this Certificate.

The insurance takes effect at 12:01 A.M. Standard Time on the Effective Date shown in the Certificate Schedule. **[**If you are Confined in a Hospital or an institution, which provides medical care or treatment on the date your insurance would otherwise become effective, you will be insured the day following formal discharge from the Hospital or institution.**]**

RIGHT TO RENEW. You may renew your insurance subject to the When Coverage Ends provision. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. We reserve the right to change the premium rates on any premium due date.

NOTICE TO COVERED PERSON. This insurance may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to carefully review all limitations.

THIRTY-DAY RIGHT TO EXAMINE CERTIFICATE. If you are not satisfied for any reason, you may return your Certificate within 30 days after receipt. When so returned your premium will be refunded and the Certificate is void from the beginning. Return the Certificate to us at our Home Office or to our authorized agent.

Our President and Secretary witness this Certificate.

Craig D. Vermie
Secretary

Brenda Clancy
President

PLEASE READ YOUR MEDICARE SUPPLEMENT INSURANCE CERTIFICATE CAREFULLY

INDEX

MEDICARE SUPPLEMENT CERTIFICATE SCHEDULE

Underwritten by: Transamerica Life Insurance Company

[Covered Person's Name:	[JOSEPHINE SAMPLE]
[Policy:	[MZ0000000H0000A]]
[Certificate Number:	[SAMPPROD]]
[Policyholder:	[ABC ASSOCIATION]]
[Effective Date of Coverage:	[January 01, 2010]]
[[Semi-Annual] Premium:	[$50.00]]
[Covered Person's Age At Issue:	[65]]

Supplemental Medicare Expense Benefits
Plan N

Hospital Benefits **Part A**	• This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150. • Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance. • This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.
Blood Benefit **Part A & B**	• This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.
Medical Benefits **Part B**	• This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, other than the co-payment amounts shown below, subject to the Medicare Part B Deductible.
• **Office Visit Co-Payment**	• $[20] per office visit
• **Emergency Room Co-Payment**	• $[50] per emergency room visit (waived if you are admitted to the Hospital and the emergency

visit is subsequently covered as a Medicare Part A Eligible Expense)

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.
Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

DEFINITIONS

When used in this Certificate, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by the Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day you are Confined in a Hospital and ends after you have been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that you are a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. You must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the person named on the Certificate Schedule who, as an eligible person, has applied for this coverage, has been accepted by us for this coverage and has paid the required premium. The Covered Person is referred to as you, your, or yours.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under the Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be you or a member of your immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be you or a member of your immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name the Policy is issued, as shown on the Certificate Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under the Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means your continuing inability to engage in the normal daily activities of a person of like age and sex in good health.

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN N

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
You will receive benefits when we receive proof that, while insured, you were Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while you use your Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When you exhaust all Medicare Part A Hospital benefits, including your Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during your lifetime. The provider shall accept the issuer's payment as payment in full and may not bill you for any balance.

HOSPICE CARE BENEFITS – PART A

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFITS – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year while you are Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) you receive in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

You will receive a benefit when we receive proof that, while insured, you incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) You must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After your deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for you, except as provided in items (3) and (4) that follows.

(3) You must pay the lesser of $**[**20**]** or the Medicare Part B coinsurance or co-payment, shown in the Certificate Schedule, for each covered health care provider office visit, including visits to medical specialist.

(4) You must pay the lesser of $**[**50**]** or the Medicare Part B coinsurance or co-payment, shown in the Certificate Schedule, for each visit to an emergency room of a Hospital. This emergency room co-payment will be waived if you are admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense.

If you discontinue or lapse Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of the Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

You will receive benefits when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 100% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

You will receive a benefit when we receive proof that, while insured, you incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of your trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. You must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Certificate Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) Your primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where you are not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Certificate Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Certificate Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under the Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of the Policy or by Medicare.

Benefits are subject to all the terms of the Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for your Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which you were medically treated or advised by a Physician within the **[**6**]** months immediately prior to your Effective Date of Coverage under the Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after you have been insured for **[**6**]** consecutive months from your Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If the Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for you to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to your enrollment under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which you were not covered under any Creditable Coverage.

If you made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which you are both 65 years of age or older and enrolled for benefits under Medicare Part B and have had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if you have had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to you as of the enrollment date.**]**

WHEN COVERAGE ENDS

Your insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew the Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under the Policy will be suspended at your request for the period (not to exceed 24 months) in which you have applied for and have been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. You must notify us of your entitlement within 90 days after the date you become entitled to such assistance.

If you lose your entitlement to such medical assistance, within the 24 month period, your coverage under the Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and you pay the required premium. Your coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan. If suspension occurs and you lose coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if you provide notice of the loss of coverage within 90 days after such loss and pay the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to you as the premium classification terms that would have applied to you had your coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of the Policy will be without prejudice to a continuous loss, which commenced while the Policy was in force. Any extension of benefits beyond the period during which the Policy was in force will be predicated upon your continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of the Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to you as follows:

(1) If the Policy is terminated by the Policyholder and is not replaced as provided below, and if you were insured on that date, you can convert to an individual policy of insurance. The individual policy, at your option, will:
    (a) provide continuation of benefits contained in the Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If you terminate membership with the Policyholder or if you are no longer eligible as a Covered Person, as defined, we will provide you the following conversion options:
    (a) the conversion coverage provided under item (1) above; or
    (b) at the option of the Policyholder, continuation of coverage under the Policy.

(3) If the Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in the Policy to you if you were covered under the Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under the Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. The first premium is due on your Effective Date of Coverage. Future premiums are due on each premium due date. Your premium mode is shown on your Certificate Schedule. **[**Your premium mode may be changed subject to our approval, by sending us a written request.**]**

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: You have a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician he chooses.

INCONTESTABILITY: No statement made by you can be used in a contest after your insurance has been in force for 2 years during your lifetime. No statement you make can be used in a contest unless it is in writing and signed by you.

MISSTATEMENT OF AGE: If your age has been misstated in the application for insurance under the Policy, the benefits payable will be those which the premiums paid would have purchased based upon your correct age, otherwise there will be an equitable adjustment of premiums.

PREMIUM REFUNDS: Any premium paid beyond the month in which your death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RIGHT TO EXAMINE POLICY: The Policy providing the benefits described in this Certificate may be examined at the offices of the Policyholder or the offices of the administrator for the insurance.

[TIME LIMIT ON CERTAIN DEFENSES. No claim for expense incurred commencing after 6 months from the date you become covered under the Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to your Effective Date of Coverage.**]**

WHEN THERE IS A CLAIM

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify you. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have you examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against the Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by the Policy will be paid as soon as written proof is received. All benefits are paid directly to you, unless you direct us otherwise. If we feel you are not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of your death, the benefit will be paid as follows: to your spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of the Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan A

Core Benefits

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person’s application and the first premium. The Effective Date of Coverage will be shown on the Covered Person’s certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person’s insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN A

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group

health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime.

No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time

written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan B

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Persons' application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN B

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90

days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan C

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B Deductible Benefit	• This Plan pays 100% of the Medicare Part B Deductible per Calendar Year.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of

The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN C

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and

(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90

days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after three years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan D

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person’s immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN D

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care

while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person

provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan F

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B

- This Plan pays 100% of the Medicare Part B

Deductible Benefit	Deductible per Calendar Year.
Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which **[**first**]** manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN F

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of

Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part B Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Calendar Year, is the Medicare Part B Deductible.

MEDICARE PART B EXCESS BENEFIT

The Covered Person will receive an additional benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if the Covered Person's Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition.

As of the date of the application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person’s

certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses his entitlement to such medical assistance, within the 24 month period, his coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:
(1) will not be subject to the Pre-Existing Conditions provision, if any;
(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and
(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
    (a) provide continuation of the benefits contained in this Policy; or
    (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:

(a) the conversion coverage provided under item (1) above; or
(b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new group Medicare Supplement policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to

us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan G

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Medicare Part B Excess Benefit	• This Plan pays 100% of the difference between the Medicare Part B billed amount and the Medicare Eligible Expense.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative

care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of

The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN G

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of

Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

MEDICARE PART B EXCESS BENEFIT

The Covered Person will receive an additional benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. We will pay 100% of the difference between the actual Medicare Part B charge, as billed (not to exceed any charge limitation established by Medicare or state law) and the Medicare Part B Eligible Expense. Benefits will not be paid if the Covered Person's Physician or medical provider accepts the Medicare Eligible Expenses as the total amount due.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be

entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if he provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan K

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 50% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit Part A & B

- This Plan pays 50% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits Part B

- This Plan pays 50% of the cost sharing of Medicare Eligible Expenses for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has

	been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 50% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**4,140**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person

described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist,

occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN K

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 50% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 50% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay 50% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, until the Out of Pocket Limit has been met, then 100%.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 50% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After the Covered Person has reached the Out of Pocket Limit shown on the Schedule, the Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;

(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90

days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date

of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the

Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan L

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 75% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Blood Benefit Part A & B

- This Plan pays 75% of the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Medical Benefits Part B

- This Plan pays 75% of the cost sharing of Medicare Eligible Expenses for Part B Medical Services, other than Part B preventive medical services, after payment of the Medicare Part B Deductible, until the Out of Pocket Limit has been met, then this Plan pays 100%.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 75% of the Medicare Part A Deductible per Benefit Period, until the Out of Pocket Limit has

	been met, then this Plan pays 100%.
Skilled Nursing Facility Benefit	• This Plan pays 75% of the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount, until the Out of Pocket Limit has been met, then this Plan pays 100%.
Part B Preventive Services Benefit	• This Plan pays 100% of the coinsurance amount for Medicare Eligible Expenses for Part B preventive medical services, subject to the Medicare Part B Deductible.
Out of Pocket Limit	• $**[**2,070**]** per Calendar Year. Once this Out of Pocket Limit has been met, this Plan pays 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year.

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:
(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person

described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist,

occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY
All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN L

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 75% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare until the Out of Pocket Limit has been met, then 100%.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense. We will pay 75% of the reasonable cost, subject to the above, until the Out of Pocket Limit has been met, then 100%.

MEDICAL BENEFITS – PART B
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses other than Part B preventive medical services. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay 75% of the cost sharing for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, until the Out of Pocket Limit has been met, then 100%.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 75% of the Medicare Part A Deductible until the Out of Pocket Limit has been met, then 100%.

SKILLED NURSING FACILITY BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement. We will pay 75% of the Actual Expenses, subject to the above, until the Out of Pocket Limit has been met, then 100%.

PART B PREVENTIVE SERVICES BENEFIT
The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for Part B preventive services, as defined by Medicare. We will pay 100% of the cost sharing for Medicare Part B preventive services, subject to the Medicare Part B Deductible.

COST SHARING AFTER OUT OF POCKET LIMIT
After the Covered Person has reached the Out of Pocket Limit shown on the Schedule, the Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred eligible expenses. We will pay 100% of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year. The Out of Pocket Limit is shown on the Schedule and will be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90

days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date

of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the

Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermie
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan M

Core Benefits

Hospital Benefits Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, subject to the Medicare Part B Deductible.

Additional Benefits

Medicare Part A Deductible Benefit

- This Plan pays 50% of the Medicare Part A Deductible per Benefit Period.

Skilled Nursing Facility Benefit

- This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.

Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE
Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN M

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A
The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 50% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care

while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person

provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may

also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person's death, the benefit will be paid as follows: to the Covered Person's spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.

TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

(Referred to as we, us, our)

This Policy is issued to the Policyholder named in the Schedule. The Policy is issued in consideration of a completed application and payment of premiums as provided by its terms.

We agree to pay benefits in accordance with all the provisions of this Policy.

Premiums are payable to us or our agent in amounts determined by this Policy. The first premium is due on the Effective Date. Future premiums are due thereafter as provided by the terms of this Policy.

EFFECTIVE DATE; RENEWAL AGREEMENT

This Policy and the insurance provided by it becomes effective 12:01 A.M. Standard Time at the Policyholder's address on the Effective Date shown on the Schedule.

RIGHT TO RENEW

This Policy is renewable at the Policyholder's option subject to the payment of premiums when due. We may not cancel or decline to renew insurance coverage except for nonpayment of premiums or material misrepresentation subject to the Incontestability provision. A Covered Person may renew his insurance subject to the Individual Termination of Insurance provision. We reserve the right to change the premium rates on any premium due date.

THIRTY-DAY RIGHT TO EXAMINE POLICY

If the Policyholder is not satisfied for any reason, the Policyholder may return this Policy within 30 days after receipt. The premium will be refunded. When so returned, the Policy is void from the beginning. Return the Policy to us at our Home Office or to our authorized agent.

The provisions found on the following attached pages form a part of this Policy as if recited over the signatures shown below. This Policy is executed on the Effective Date, at Cedar Rapids, Iowa.

Craig D. Vermeer
Secretary

Brenda Clancy
President

GROUP MEDICARE SUPPLEMENT INSURANCE POLICY
NON-PARTICIPATING

INDEX

MEDICARE SUPPLEMENT SCHEDULE

The Insurer:	Transamerica Life Insurance Company Cedar Rapids, Iowa (referred to as we, us and our)
Group Policy Number:	**[**MZ0100585H0005A**]**
Effective Date:	**[**January 1, 2010**]**
Anniversary Date:	**[**January 1, 2011**]**
Policyholder:	**[**ABC ASSOCIATION**]** (referred to as you, your and yours)

Supplemental Medicare Expense Benefits
Plan N

Core Benefits

Hospital Benefits
Part A

- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 61 - 90.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for days 91 - 150.
- Upon exhaustion of all Medicare Part A Hospital benefits, including Lifetime Reserve Days, this Plan pays 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime.
- This Plan pays 100% of Medicare Part A Eligible Expenses not covered by Medicare for Hospice Care and Respite Care.

Blood Benefit
Part A & B

- This Plan pays the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells as defined by federal regulation) each year.

Medical Benefits
Part B

- This Plan pays the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount of Medicare Eligible Expenses, other than the co-payment amounts shown below, subject to the Medicare Part B Deductible.

• **Office Visit Co-Payment**	• $**[**20**]** per office visit
• **Emergency Room Co-Payment**	• $**[**50**]** per emergency room visit (waived if the Covered Person is admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense)

Additional Benefits

Medicare Part A Deductible Benefit	• This Plan pays 100% of the Medicare Part A Deductible per Benefit Period.
Skilled Nursing Facility Benefit	• This Plan pays the Actual Expenses, from the 21st to the 100th day, but not to exceed the Skilled Nursing Facility benefit coinsurance amount.
Foreign Country Travel Benefit	
• **Benefit Deductible**	• $250 per Calendar Year
• **Benefit Amount**	• Subject to the Benefit Deductible, this Plan pays 80% of Medicare Eligible Expenses.
•	
• **Lifetime Maximum Benefit Amount**	• $50,000

TABLE OF PREMIUMS

Monthly notifications will be sent as rates are approved by state.

DEFINITIONS

When used in this Policy, the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

ACTUAL EXPENSES means the actual charges made by a Physician, Hospital, or other medical service provider for services covered by this Policy, not to exceed the charge limitations established by the Federal Medicare Program or state law.

BENEFIT PERIOD means a period of time for which benefits are payable. It begins on the first day the Covered Person is Confined in a Hospital and ends after the Covered Person has been out of the Hospital or Skilled Nursing Facility for 60 consecutive days.

CALENDAR YEAR means the period of time from January 1 through December 31 in the same year.

CONFINED or CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. The Covered Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. Confinement does not include treatment received in the outpatient department of the facility. Outpatient treatment means service rendered for a period of less than 24 hours.

COVERED PERSON means the insured Eligible Person covered under this Policy. A certificate will be provided to each Covered Person.

ELIGIBLE PERSON means a Member who is covered under Parts A and B of Medicare and who is age 65 or older.

FOREIGN COUNTRY means any country which is excluded from coverage under Medicare.

HOSPICE CARE AND RESPITE CARE means: for hospice care, an approach to treatment that recognizes that the impending death of an individual warrants a change in the focus from curative care to palliative care (relief of pain and other uncomfortable symptoms); for respite care, hospice care provided as an inpatient in a hospice.

HOSPITAL means an institution, which meets all of the following requirements:

(1) it must be operated according to law;
(2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an in-patient basis for which a charge is made;
(3) it must provide diagnostic and surgical facilities supervised by Physicians;
(4) Registered Nurses must be on 24 hour call or duty;
(5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

A Hospital is not a rest, convalescent, extended care, rehabilitation or Skilled Nursing Facility; a place which primarily treats mental illness, alcoholism or drug addiction; nor does it include any ward, wing or other section of the Hospital that is used for such purposes. A Hospital will include an institution, which has an agreement as a provider of hospital services under Section 1866 of Title XVIII. **[**Hospital also includes a Christian Science sanatorium, which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

INJURY means bodily injury caused by an accident. The accident must occur while insurance is in force under this Policy. The Injury must be the direct cause of loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

MEDICARE ELIGIBLE EXPENSES means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

MEDICARE PART A DEDUCTIBLE means the fixed amount Medicare does not pay during the first 60 days of Hospital Confinement during a Benefit Period. This amount is set each year by Medicare.

MEDICARE PART B DEDUCTIBLE means the fixed amount Medicare does not pay for Part B Medicare Eligible Expenses during a Calendar Year. This amount is set each year by Medicare.

MEMBER means: (a) a member of **[**ABC Association **[**(as defined in the **[**ABC Association**]** Constitution and Bylaws as amended from time to time)**][**;**]** **[**and**]** **[**(b) an active **[**or retired**]**, full-time employee who is/was regularly scheduled to work at least **[**twenty hours**]** per week **[**on the staff of **[**ABC Association**]][**;**][** and**]** **[**(c) the lawful spouse**[**, unless legally separated,**]** of any person described in **[**(a)**]** **[**or**]** **[**(b)**]** above**][**;**][** and**]** **[**(d) the parents, parents-in-law, step-parents-in-law, grandparents and grandparents-in-law of any person described in **[**(a),**]** **[**(b)**]** **[**or**]** **[**(c)**]** above**]**.

NURSE means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). **[**Nurse includes a Christian Science Nurse listed as such in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Nurse may not be the Covered Person or a member of the Covered Person's immediate family.

PHYSICIAN means a person licensed by the state in which he is resident to practice the healing arts. The Physician must be practicing within the scope of his license for the service or treatment given. **[**Physician includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adhere to the rules and regulations of The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.**]** A Physician may not be the Covered Person or a member of the Covered Person's immediate family.

POLICY means the contract issued to the Policyholder providing the benefits described.

POLICY MONTH means the period of time starting on the **[**first**]** day of the month; it ends on the **[**last**]** day of the same month.

POLICYHOLDER means the legal entity in whose name this Policy is issued, as shown on the Schedule.

SICKNESS means an illness or disease, which first manifests itself after the Effective Date of Insurance and while insurance for the Covered Person is in force under this Policy.

SKILLED NURSING FACILITY means an institution, which meets all of the following requirements:
(1) it must be operated pursuant to law;
(2) it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
(3) it must be primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing Services under a licensed Physician's supervision;
(4) Registered or Licensed Practical Nurses must supervise 24 hours a day;
(5) a daily record for each patient must be maintained.

This definition does not include a:
(1) rest home or similar facility;
(2) home or facility for the aged;
(3) home or facility for drug addicts or alcoholics;
(4) home or facility for care or treatment of mental diseases or disorders; or
(5) home or facility for custodial or educational care.

[Skilled Nursing Facility also includes a Christian Science sanatorium which is operated or listed and certified by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc. at the time the service is provided and which operates according to the rules and regulations of the Church.**]**

SKILLED NURSING SERVICES means services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

TOTAL DISABILITY means the continuing inability of the Covered Person to engage in the normal daily activities of a person of like age and sex in good health.

ELIGIBLITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBLITY

All Eligible Persons who are covered under Parts A and B of Medicare and are age 65 or older will be eligible to become Covered Persons.

EFFECTIVE DATE OF INSURANCE

Issuance of a certificate is not a waiver of any of the following conditions.

Each Eligible Person will become insured under this Policy as a Covered Person following acceptance by us of the Eligible Person's application and the first premium. The Effective Date of Coverage will be shown on the Covered Person's certificate.

[If a Covered Person is Confined in a Hospital or an institution, which provides medical care and treatment on the date the Covered Person's insurance would otherwise become effective, the Covered Person will be insured the day following formal discharge from the Hospital or institution.**]**

[However, we will waive deferment of coverage during any period of open enrollment where an application is submitted during the 6 month period beginning with the first month in which the Covered Person (who is 65 years of age or older) first enrolled for benefits under Medicare Part B.**]**

SUPPLEMENTAL MEDICARE EXPENSE BENEFITS
PLAN N

PART I – BASIC (CORE) PLAN BENEFITS

HOSPITAL BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person was Confined in a Hospital and incurred Part A Medicare Eligible Expenses. Confinement must be for Sickness or Injury. The following benefits are payable during a Benefit Period:

(1) From day 61 through day 90, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare.

(2) After the 90th day, while the Covered Person uses Medicare Lifetime Reserve Days, we will pay the Part A Medicare Eligible Expenses to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

(3) When the Covered Person exhausts all Medicare Part A Hospital benefits, including Medicare Lifetime Reserve Days, we will pay 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a maximum benefit of an additional 365 days during the Covered Person's lifetime. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

HOSPICE CARE BENEFITS – PART A

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses for Hospice Care and Respite Care. We will pay 100% of the cost sharing for all Part A Medicare Eligible Expenses for Hospice Care and Respite Care to the extent not covered by Medicare.

BLOOD BENEFIT – PART A and PART B

Part A: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year while Confined in a Hospital or Skilled Nursing Facility. Only blood, which is not replaced or not already covered by Part B, is an eligible expense.

Part B: We will pay the reasonable cost for the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by federal regulations) the Covered Person receives in a Calendar Year. Only blood, which is not replaced or not already considered under Part A, is an eligible expense. Reimbursement for the first three pints of blood will not be subject to the Medicare Part B Deductible or Medicare Part B coinsurance. Additional Medicare eligible blood charges will be subject to the Medicare Part B Deductible and paid the same as any other Part B Medicare Eligible Expense.

MEDICAL BENEFITS – PART B

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part B Medicare Eligible Expenses. The expenses must be for a Sickness or Injury. The benefit is payable regardless of Confinement in a Hospital. The benefits will be paid as follows:

(1) The Covered Person must incur a Calendar Year deductible equal to the Medicare Part B Deductible.

(2) After the Covered Person's deductible is satisfied, we will pay the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, for Part B Medicare Eligible Expenses which are not paid by Medicare for that Covered Person, except as provided in items (3) and (4) that follows.

(3) The Covered Person must pay the lesser of $**[**20**]** or the Medicare Part B coinsurance or co-payment, shown in the Schedule, for each covered health care provider office visit, including visits to medical specialist.

(4) The Covered Person must pay the lesser of $**[**50**]** or the Medicare Part B coinsurance or co-payment, shown in the Schedule, for each visit to an emergency room of a Hospital. This emergency room co-payment will be waived if the Covered Person is admitted to the Hospital and the emergency visit is subsequently covered as a Medicare Part A Eligible Expense.

If the Covered Person discontinues or lapses Part B Medical Insurance under Medicare, we will not pay any benefits for incurred expenses which would otherwise have been covered under the terms of this Policy.

PART II – ADDITIONAL BENEFITS

MEDICARE PART A DEDUCTIBLE BENEFIT

The Covered Person will receive benefits when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses. Those expenses must be applied towards the satisfaction of the Medicare Part A Deductible. Only Medicare approved expenses will be payable under this benefit. The maximum amount payable under this benefit, per Benefit Period, is 100% of the Medicare Part A Deductible.

SKILLED NURSING FACILITY BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred Part A Medicare Eligible Expenses when Confined in a Skilled Nursing Facility and received Skilled Nursing Services. Benefits will be paid from the 21st through the 100th day of Confinement. Skilled Nursing Facility Confinement must begin within 30 days after the end of a Hospital Confinement, which lasted at least three days. The Skilled Nursing Facility Confinement must be due to the same or related Injury or Sickness as the prior Hospital Confinement.

FOREIGN COUNTRY TRAVEL BENEFIT

The Covered Person will receive a benefit when we receive proof that, while insured, the Covered Person incurred expenses for medically necessary emergency Hospital, Physician or medical care while in a Foreign Country. Such care must be provided within the first 60 consecutive days of the Covered Person's trip outside the United States. Only those billed expenses, which would have been considered Medicare Eligible Expenses had the care been provided in the United States, will be considered under this benefit. The Covered Person must first incur expenses up to the Foreign Country Travel Benefit Deductible, shown in the Schedule, before expenses are payable under this benefit. This benefit is subject to the following conditions:

(1) The Covered Person's primary residence is in the United States; and
(2) The treatment rendered must be for an Injury or sudden and unexpected onset of a Sickness requiring immediate medical attention.

Benefits will not be payable for any charges incurred where the Covered Person is not required to pay. If expenses are paid by the Foreign Country, we will deduct the amount paid from the benefits payable under this benefit and pay the remaining eligible expenses. After the Foreign Country Travel Benefit Deductible has been met, we will pay the Benefit Amount shown in the Schedule. Benefits payable will be limited to the Lifetime Maximum Benefit amount shown in the Schedule.

PART III - OTHER PROVISIONS APPLICABLE TO MEDICARE SUPPLEMENT BENEFITS

The benefits provided under this Policy will automatically change to coincide with any changes in the Medicare deductible or coinsurance.

Any benefit paid will not exceed the expense actually incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits are subject to all the terms of this Policy.

EXCLUSIONS

Benefits will not be paid for any expenses, which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.

[PRE-EXISTING CONDITION LIMITATION

No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as an Injury sustained or a Sickness for which the Covered Person was medically treated or advised by a Physician within the **[**6**]** months immediately prior to his Effective Date of Coverage under this Policy.

Expenses for these conditions will not be eligible for consideration unless incurred after the Covered Person has been insured for **[**6**]** consecutive months from his Effective Date of Coverage.

Creditable Coverage - means a group health plan; health insurance coverage; Part A or B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 of that Act; Chapter 55 of Title 10 United States Code (Champus/Tricare); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program); a public health plan as defined in federal regulation; or a health benefit plan under Section 5(e) of the Peace Corps Act.

If this Policy replaces Creditable Coverage, such as, in force Medicare Supplement or primary hospital and medical reimbursement insurance coverage that has been in force within the past 63 days, then this Pre-Existing Condition Limitation will be waived for each Covered Person to the extent it was satisfied for similar benefits under the prior Creditable Coverage. A period of Creditable Coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a 63 day period during all of which the individual was not covered under any Creditable Coverage.

If a Covered Person made application for the Certificate prior to or during the 6 month period beginning with the first day of the month in which the individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B and has had a continuous period of Creditable Coverage of at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition;

As of the date of application, if the Covered Person has had a continuous period of Creditable Coverage that is: at least **[**6**]** months, we will not exclude benefits based on a Pre-Existing Condition; or, less than **[**6**]** months, we shall reduce the period of any Pre-Existing Condition exclusion by the aggregate of the period of Creditable Coverage applicable to the Covered Person as of the enrollment date.**]**

INDIVIDUAL TERMINATION OF INSURANCE

A Covered Person's insurance automatically ends on the first of the following dates:

(1) The date the Policyholder cancels or does not renew this Policy, subject to the Conversion Privilege provision;
(2) On the expiration of the Grace Period, if the required premium is not paid.

If a Covered Person is no longer a Member due to divorce, legal separation or annulment of a marriage, that Covered Person can continue coverage under this Policy. That Covered Person's certificate will remain in force, subject to all other terms and conditions of this Policy, and the payment of the required premium.

SUSPENSION OF POLICY BENEFITS DUE TO MEDICAID ENTITLEMENT: Benefits and premiums under this Policy will be suspended at the request of the Covered Person for the period (not to exceed 24 months) in which the Covered Person has applied for and has been determined to be

entitled to receive medical assistance under Title XIX of the Social Security Act. The Covered Person must notify us of the Covered Person's entitlement within 90 days after the date the Covered Person becomes entitled to such assistance.

If the Covered Person loses the Covered Person's entitlement to such medical assistance, within the 24 month period, the Covered Person's coverage under this Policy will be automatically reinstituted as of the termination date of such loss, provided we are notified of the loss of entitlement within 90 days after such loss and the Covered Person pays the required premium. The Covered Person's coverage will be reinstituted at the then current premium rates.

Benefits and premiums will be suspended (for any period that may be provided by federal regulation) at the request of the Covered Person if the Covered Person is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If suspension occurs and the Covered Person loses coverage under the group health plan, the Policy shall be automatically reinstated, effective as of the date of loss of such coverage, if the Covered Person provides notice of the loss of coverage within 90 days after such loss and pays the premium due from that date.

The reinstituted coverage:

(1) will not be subject to the Pre-Existing Conditions provision, if any;

(2) will be the same or substantially similar to the coverage in effect before the date of such suspension; and

(3) will provide for classification of premiums on terms at least as favorable to the Covered Person as the premium classification terms that would have applied to the Covered Person had the Covered Person's coverage not been suspended.

EXTENSION OF BENEFITS: The Policyholder's cancellation or non-renewal of this Policy will be without prejudice to a continuous loss, which commenced while this Policy was in force. Any extension of benefits beyond the period during which this Policy was in force will be predicated upon the Covered Person's continuous Total Disability. Benefits will be limited to the maximum benefit amounts and any other limitations of this Policy. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

CONVERSION PRIVILEGE: A Conversion Privilege is available to all Covered Persons as follows:

(1) If this Policy is terminated by the Policyholder and is not replaced as provided below, all Covered Persons who were insured on that date can convert to an individual policy of insurance. The individual policy, at the Covered Person's option, will:
   (a) provide continuation of the benefits contained in this Policy; or
   (b) provide only the Basic (Core) Benefits.

(2) If a Covered Person terminates membership with the Policyholder or is no longer eligible as a Covered Person, as defined, we will provide the following conversion options to that Covered Person:
   (a) the conversion coverage provided under item (1) above; or
   (b) at the option of the Policyholder, continuation of coverage under this Policy.

(3) If this Policy is replaced by another group Medicare Supplement policy purchased by the Policyholder, the issuer of the new group Medicare Supplement policy will offer comparable coverage contained in this Policy to all Covered Persons covered under this Policy on its date

of termination. Coverage under the new policy will not result in any exclusion for pre-existing conditions that would have been covered under this Policy, which is being replaced.

PREMIUMS

We provide insurance coverage in return for premium payment. Premiums are payable by a Covered Person. The Covered Person's first premium is due on the Covered Person's Effective Date of Coverage. Premiums are paid to us on or before the due date. The initial monthly premium rates are shown on the Table of Premiums.

Premiums may be paid monthly, quarterly, semi-annually, or annually. The premium mode may be changed by sending us a written request. Upon our approval, the change will be made.

PREMIUM CHANGES: We have the right to change the premium rates on any premium due date. We will provide written notice at least **[**31**]** days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed. Premiums may be changed to coincide with changes in Medicare as of the beginning of the Calendar Year.

GRACE PERIOD: This Policy has a 31-day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums, which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

[UNPAID PREMIUM. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.**]**

GENERAL PROVISIONS

ACTS OF THE POLICYHOLDER: In administering this Policy all Covered Persons must be treated equally. We will rely on your acts.

CERTIFICATES: Certificates will be provided for each Covered Person. They will describe the coverages provided to whom benefits are paid and the provisions of this Policy which apply to Covered Persons.

The certificate is not a part of this Policy. Any conflict between the terms of the certificate and this Policy will be decided in favor of the Policy. A copy of the Policy may be examined at your office or the office of the group insurance administrator.

If the Covered Person is not satisfied for any reason, the Covered Person may return the Covered Person's certificate within **[**30 days**]** after receipt. The Covered Person's premium will be refunded. When so returned, the certificate will be void from the beginning. The certificate must be returned to us at our Home Office or to our authorized agent. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

CHOICE OF PHYSICIAN: The Covered Person is free to be treated by any Physician the Covered Person chooses.

CLERICAL ERROR: Clerical errors or delays in keeping records for this Policy will: a) not deny insurance which would otherwise have been granted; b) not extend insurance which otherwise would have ceased; and c) will be subject to a fair adjustment of premium and benefits to correct the error.

CONFORMITY TO LAW: Any provision of this Policy which is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

ENTIRE CONTRACT; CHANGES: This Policy, your application, and any other attachments is the entire contract between us. Any statement you or a Covered Person makes is a representation and not a warranty. No statement will be used by us to void or reduce benefits unless that statement is a part of the written application.

This Policy may be changed at any time by written agreement between us. Only our President, Vice President or Secretary may change or waive the provisions of this Policy. No agent or other person may change this Policy or waive any of its terms. The change will be endorsed on this Policy.

INCONTESTABILITY: After this Policy has been in force for 2 years, it can only be contested for non-payment of premiums. No statement made by a Covered Person can be used in a contest after the Covered Person's insurance has been in force for 2 years during the Covered Person's lifetime. No statement a Covered Person makes can be used in a contest unless it is in writing and signed by the Covered Person.

MISSTATEMENT OF AGE: If the age of a Covered Person has been misstated in the application for insurance under this Policy, the benefits payable will be those which the premiums paid would have purchased based upon the Covered Person's correct age, otherwise there will be an equitable adjustment of premiums.

NON-PARTICIPATING: This Policy is a non-participating Policy; it does not share in our surplus.

PREMIUM REFUNDS: Any premium paid beyond the month in which a Covered Person death occurs will be refunded. The refund will be paid in a lump sum within 30 days after proof of death has been furnished to us.

RECORDS: Sufficient records must be maintained by you to show the names of all Covered Persons; the dates Covered Persons became insured; and any such other information required by us to administer this Policy.

RIGHT TO TERMINATE: You may end this Policy by giving written notice to us **[**31**]** days prior to the desired date of termination. You must notify all Members of such Policy termination.

[TIME LIMIT ON CERTAIN DEFENSES: No claim for expense incurred commencing after 6 months from the date the Covered Person becomes covered under this Policy, shall be reduced or denied on the ground that an Injury or a Sickness had existed in the **[**6**]** months prior to the Effective Date of Coverage for such Covered Person.**]**

WORKER'S COMPENSATION: This Policy is not a Worker's Compensation Policy. It does not satisfy any requirement for coverage by Worker's Compensation insurance.

CLAIM PROVISIONS

NOTICE OF CLAIM: We must be given written notice of claim within 20 days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain the claimant's name and enough information to identify the Covered Person. Notice may be mailed to our Home Office or to our agent.

CLAIM FORMS: When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof must be sent to us within 90 days after the date the loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible.

PHYSICAL EXAMINATION AND AUTOPSY: At our expense, we have the right to have the Covered Person examined as often as necessary while a claim is pending. At our expense, we may require an autopsy unless the law forbids it.

LEGAL ACTIONS: No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action will be brought after 3 years from the time written Proof of Loss is required to be given. If a time limit of this Policy is less than allowed by the laws of the state where the Covered Person lives, the limit is extended to meet the minimum time allowed by such law.

PAYMENT OF CLAIMS: Claims for benefits provided by this Policy will be paid as soon as written proof is received. All benefits are paid directly to the Covered Person, unless the Covered Person directs us otherwise. If we feel the Covered Person is not able to give a valid receipt for the payment of benefits or if a benefit is unpaid at the time of the Covered Person’s death, the benefit will be paid as follows: to the Covered Person’s spouse, parent(s), child(ren), brother(s), sister(s), or estate. Any payment we make in good faith will fully discharge us to the extent of the payment.

RIGHT OF RECOVERY: If payment for claims exceeds the maximum amount payable under any benefit provisions of this Policy, we have the right to recover the excess of such payments.